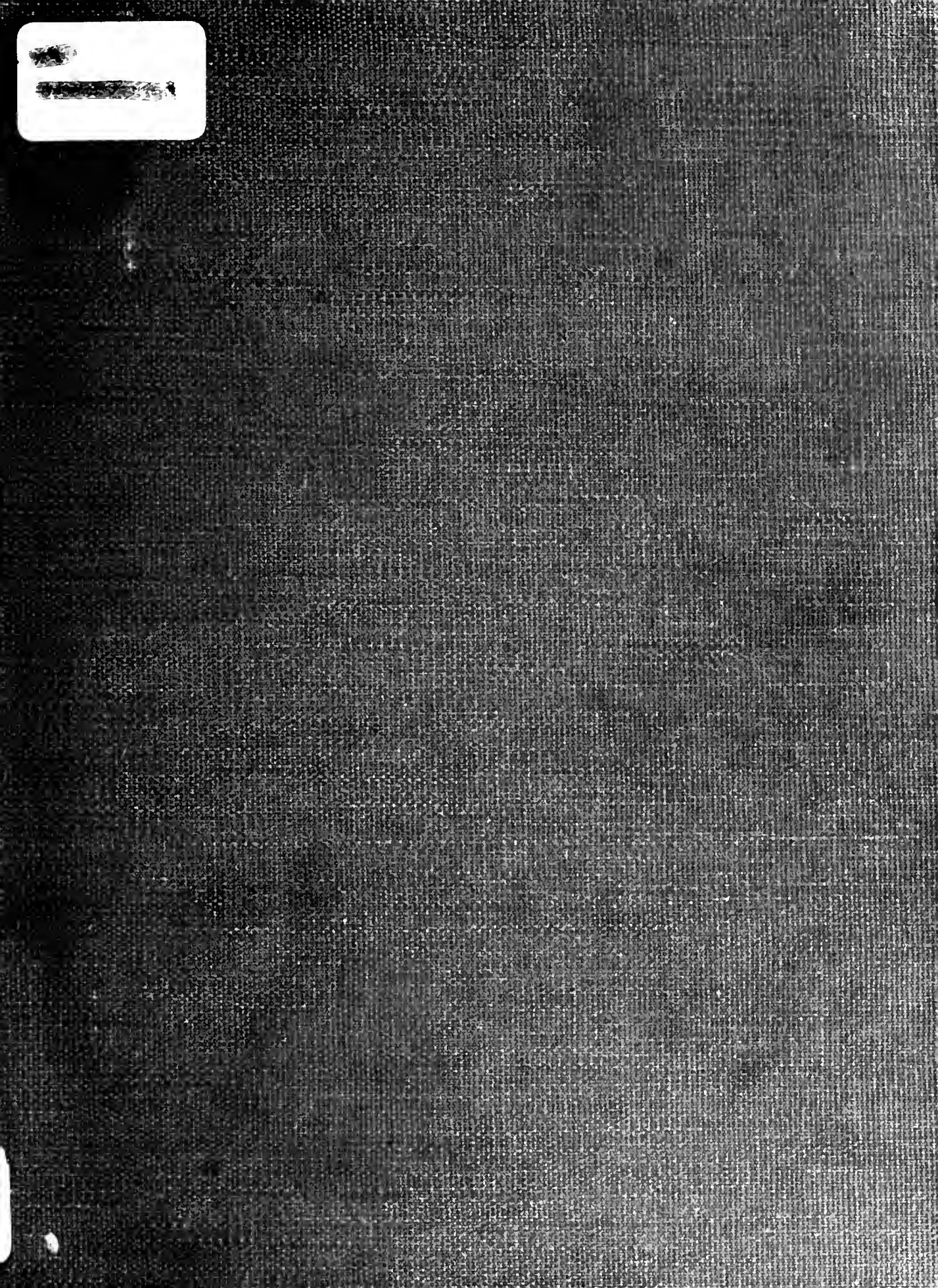

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Cystic Fibrosis and Family Stress

Modern Theories of Communication

Services to Neglected Children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

VOLUME 7
NUMBER 1
JANUARY–FEBRUARY 1960



A FUTURE PRESIDENT? Conservation of the Nation's most precious asset, its children, has been the focus of decennial White House Conferences on children since Theodore Roosevelt called together a conference on dependent children back in 1909. On pages 3–8 the Chief of the Children's Bureau describes how over the years these Conferences have become a national tradition and something of what they have so far achieved.

The next Conference, the Golden Anniversary White House Conference on Children and Youth will be held in Washington, March 27–April 2.

In addition to her hospital responsibilities Dr. Dorothy Andersen carries a professorship in pathology at the College of Physicians and Surgeons, Columbia University. A graduate of Mount Holyoke College, with a medical degree from Johns Hopkins University, she has done considerable research in the fields of pediatric pathology, cystic fibrosis, celiac disease, glycogen storage diseases, and congenital heart diseases.

In the 8 years since he has been in the Behavioral Studies Section, Public Health Service, Godfrey M. Hochbaum has devoted his attention to studying the reactions of various segments of the public to health problems and health programs. With a Ph. D. in psychology and sociology from the University of Minnesota, he also teaches psychology at American University. A native of Austria, Dr. Hochbaum served in the U.S. Army in World War II.

With a master's degree from Western Reserve University, Margaret A. Dunham, left, was dietitian at the Indiana University Medical Center before joining the staff of the Indiana State Board of Health 10 years ago. Lucille DeVoe, right a social work graduate of the University of Indiana, has worked in public welfare in Indiana since 1936, at first with a county department and since 1949 with the State.

Before coming to the Children's Bureau 13 years ago, Annie Lee Sandusky was head of the casework department at Atlanta University's School of Social Work. Previously she was consultant on social services to families and children in the aid-to-dependent-children program of the Illinois Public Aid Commission. A graduate of the School of Social Service Administration, University of Chicago, she has also served as probation officer in the Juvenile Court of Cook County.

Now supervisor of the licensing program of the Kansas State Board of Health's Division of Maternal and Child Health, Dr. Paula van der Waals came to this country from The Netherlands in 1955. During the 20 years when she was honorary secretary for the child-caring agency Tot Steun, she practiced medicine in a private hospital in Amsterdam and in the Amsterdam Health Department. She has also worked in a missionary hospital in Indonesia.

## ◀ *the authors*

# THE GROWTH AND MEANING OF WHITE HOUSE CONFERENCES ON CHILDREN AND YOUTH

KATHERINE B. OETTINGER
*Chief, Children's Bureau*

EACH DECADE of the twentieth century the United States has held a great national Conference devoted to the circumstances and prospects of the Nation's children. Convened in Washington, sponsored by the President of the United States, and having one or more sessions in the White House, they have been known as White House Conferences on Children.

The sixth Conference—the Golden Anniversary White House Conference on Children and Youth—will be held March 27–April 2 of this year. Its purpose is to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity. Preparations for it, now in full crescendo, were begun as long as 4 years ago.

For this Conference, the Children's Bureau assumed its traditional role as initiator by alerting the President and gathering together suggestions for planning. A National Committee of 92 persons, appointed by President Eisenhower in the fall of 1958, is responsible for Conference planning. This committee includes community leaders, professionals of various disciplines, and 10 young people of high school or college age selected for their leadership in school, church, or community activities.

A partnership carried over from the 1950 Conference among Federal agencies concerned with children, State committees on children and youth, and national organizations has made planning for this Golden Anniversary Conference far broader in scope than for any of the previous White House Conferences on Children. Since it is being built solidly on previous White House Conferences, a look back at the story of the earlier Conferences seems of special interest at this point. For, in a very real sense, "our past acclaims our future."

The previous White House Conferences on Children were held in 1909, 1919, 1930, 1940, and 1950. Each has exerted a direct and powerful influence on the welfare of the Nation's children. Each has been concerned with a problem typical of the decade in which it occurred.

The first two Conferences, though sponsored by the President and with sessions held at the White House, were called White House Conferences only in retrospect. In 1930, "White House" became part of the Conferences' official title.

Both the focus and the theme of the Conferences have broadened over the years. Participants have increased from a few hundred specialists to thousands of citizens of various walks of life coming together out of concern for children. Physicians, social workers, educators, community leaders, members of labor unions, representatives of civic groups, religious leaders, parents—all citizens who cherish and serve children—have taken part in and contributed to the problems under scrutiny at the various Conferences. Participants in the 1960 meeting include the 7,000 persons invited to the Conference at Washington and countless others who have taken part in the State and local preparations.

Every White House Conference has had members from foreign lands, especially the 1919 and 1950 Conferences. As a result, their influence has ex-

Final session and banquet of the Conference on the Care of Dependent Children, called by President Theodore Roosevelt.

tended far beyond the boundaries of the United States. Invitations to the 1960 Conference will go to 500 representatives of other countries.

### *Origin of the Conferences*

The idea for the first White House Conference on Children originated with James E. West, a lawyer who had been raised in an orphanage and had later directed its program for boys. There his lifelong interest in homeless children had its origin.

West became assistant attorney of the Department of the Interior and while serving in this capacity in 1908 took part in a conference on the conservation of natural resources convened at the White House by President Theodore Roosevelt. From this experience, he derived the idea for a conference on children. To West, the Nation's most important natural resource was children—and their conservation of utmost importance to the Nation's future.

Early in 1908 West became associated with a "child rescue campaign" being conducted by Theodore Dreiser—then editor of the *Delineator*—"for the child that needs a home and the home that needs a child." Later that year, West represented the *Delineator* at the twenty-fifth anniversary meeting of the National Home Finding Society in Chicago—a conference that stressed the importance of a greater national effort on behalf of children dependent on persons outside their own families for care. Afterward, West and Dreiser went to the White House to discuss the needs of dependent children with President Roosevelt. West urged the President to sponsor a national conference on dependent children as a way to "greatly advance the cause of the dependent child." The President asked that the idea be presented to him in more detail.

West began by interesting many of the national leaders in child welfare in joining him in the proposal. On December 22, 1908, they sent a letter to the President, drafted by West and Dreiser, outlining a proposed conference. Following are excerpts from this letter:

> The State has dealt generously with her troublesome children; but what is she doing for those who make no trouble but are simply unfortunate? . . . Some are orphans or half orphans; some are abandoned by heartless parents; some are victims of cruelty or neglect . . . . The problem of the dependent child is acute; it is large; it is national. We believe that it is worthy of national consideration . . . .

As a result President Roosevelt called 200 persons to a conference concerned with child care, addressing some of the invitations himself on Christmas Day, 1908.

### *Dependent Children (1909)*

The second half of the nineteenth century had been the "institutional era" in child care. In a sense, the 1909 Conference was a protest against this type of care for children.

The Conference was held on January 25 and 26 and, at the request of the President, the first meeting convened in the White House. In his address, the President said:

> There can be no more important subject from the standpoint of the Nation than that with which you are to deal, because when you take care of the children, you are taking care of the Nation of tomorrow; and it is incumbent upon every one of us to do all in his or her power to provide for the interests of those children whom cruel misfortune has handicapped at the very outset of their lives.

Some of the words in the conclusions of this Conference are still echoing down the years:

> Home life is the highest and finest product of civilization. It is the great molding force of mind and character. Children should not be deprived of it except for urgent and compelling reasons . . . As to the children who . . . must be removed from their own homes, or have no homes . . . they should be cared for in families whenever practicable. The carefully selected foster home is for the normal child the best substitute for the natural home . . . .

This Conference had far-reaching effects on child care in the United States. It recommended a Federal Children's Bureau, which was established by Congress in 1912 after an arduous campaign by the Na-

tional Child Labor Committee. Its recommendation for a voluntary national child welfare agency was realized with the establishment of the Child Welfare League of America a few years later.

The Conference's strong declaration in favor of the care of children in their own homes led to a movement for mothers' pensions which swept the country during the next decade. A recommendation of family care instead of institutional care contributed greately to the development of adoption agencies and still more to the boarding-out care of children unavailable for adoption. Institutions composed of cottages for small groups instead of large congregate buildings were another development that followed upon a Conference suggestion.

### *Child Welfare Standards (1919)*

Nothing in the 1909 Conference proceedings suggested that White House Conferences on Children should be called at 10-year intervals. That a second one was called—and the pattern established—was due to Julia Lathrop, the first chief of the Children's Bureau. By initiating this Conference, she set the precedent for the Bureau's initiation of all succeeding Conferences.

During the second year of World War I, in April 1918, the Children's Bureau had, with the approval of President Woodrow Wilson, proclaimed "Children's Year"—a campaign designed to arouse the Nation to the importance of conserving childhood in times of national peril. At the war's end, Miss Lathrop saw a national conference as a logical channel for establishing standards of child health and welfare on a firmer base. Funds for the Conference came from an allotment from the President's Emergency Fund.

This Conference had a broader scope than its predecessor.

A small meeting of some 200 specialists, a few laymen, and a few foreign visitors in Washington in May 1919 was followed by a series of 8 regional conferences attended by laymen and professionals in health, welfare, and other fields affecting children. The regional conferences carried the standards defined at the Washington meeting out to the people of the Nation—and this perhaps accounts for their great influence in the following decade.

Two themes were closely interwoven throughout the Washington Conference—the necessity for more public effort in behalf of children and of expending that effort in the light of the individual characteristics of each child and his family. Whatever the phase of the child's well-being that was under discussion, the conferees frankly demanded or boldly presupposed public provision of instruction, service, money, equipment, or legislative protection.

Minimum standards for the public protection of the health of mothers and children, children entering employment, and children in need of special care were recommended at the Washington meeting. After consideration by the regional conferences, they were revised by a special committee of five persons.

The standards concerning children entering employment were considerably in advance of the legislation of the time—and had an important influence on Federal and State child labor legislation in the following decades. The standards for the protection of children in need of special care were similar to those recommended by the 1909 Conference.

However, the standards on the protection of maternity and infancy proved to be the most influential. Representing the first steps in a nationwide movement for the protection of maternity and infancy, they resulted in the enactment of the Sheppard-Towner Act, passed by the Congress in 1921. Under this act the Federal Government contributed to the development of facilities throughout the country for the better protection of mothers and infants. Originally authorized for a 5-year period, the act was subsequently extended for 2 years—until June 30, 1929, when it ceased to operate.

Upon the foundation of the work done under the Sheppard-Towner Act was erected the Federal-State program for maternal and child health now carried out under the Social Security Act of 1935.

### *Child Health and Protection (1930)*

The third White House Conference found the United States in an industrial depression. The times were troubled, ways of meeting the emergency were subjects of controversy, and child welfare workers were overwhelmed by the suffering among children and their families.

In July 1929 President Herbert Hoover issued a call for a White House Conference on Child Health and Protection "to study the present status of the health and well-being of the children in the United States and its possessions; to report what is being done; to recommend what ought to be done and how to do it." The President also established a planning committee for the Conference made up of eminent physicians, social workers, educators, and laymen. Financial resources were provided for the Conference through a grant from funds left over from

money raised for post-World War I European relief.

The Conference was attended by 1,200 delegates and 2,000 guests. Its four sections dealt with medical service, public health service and administration, education and training, and handicapped children. Conferees were, for the most part, specialists in these fields.

This was the first White House Conference to use radio to bring its deliberations to millions of mothers and fathers throughout the country.

The President's charge to the Conference had an emotional appeal:

> We approach all problems of children with affection. Theirs is the province of joy and humor. They are the most wholesome part of the race, the sweetest for they are fresher from the hands of God. Whimsical, ingenious, mischievous, we live a life of apprehension as to what their opinion may be of us; a life of defense against their terrifying energy; we put them to bed with a sense of relief and a lingering of devotion.

The fundamental purpose of this Conference is to set forth an understanding of those safeguards which will assure them health of mind and body.

Following are excerpts from the reports:

> The first cardinal principle in the education and training for a democratic society is that each individual child should develop to his greatest possible level of attainment . . . .
>
> . . .
>
> To the doctor the child is a typhoid patient; to the playground supervisor, a first baseman; to the teacher, a learner of arithmetic. At different times, he may be different things to each of these specialists but too rarely is he a whole child to any of them . . . .
>
> . . .
>
> No economic need in prosperous America can be urged as justification for robbing a child of his childhood . . . .
>
> If we want civilization to march forward it will march not only on the feet of healthy children, but beside them . . . must go . . . those children we call handicapped . . . .

This Conference produced the Children's Charter, containing 19 vibrant statements as to what every child needs for his education, health, welfare, and protection. No other declaration on the rights of children has been so widely distributed here and abroad.

Followup programs were organized in many States. Some of them represented the first Statewide attempt to bring together various professional groups and agencies to review children's needs and improve services.

The Conference undoubtedly contributed to the great advance in the field of pediatrics and pediatric education that followed it. Its recommendations also served as a base for the children's measures in the Social Security Act.

Thirty-two volumes of Conference findings appeared over a period of several years, an era of detailed factfinding and report making. But no attempt was made to condense these findings into a program of action.

### *Children in a Democracy (1940)*

The title of the 1940 White House Conference on Children in a Democracy was logical in a world so threatening to democracy itself. This Conference was concerned with all children, not merely with those handicapped by circumstances. Its baseline was family and community life. Its purpose was to develop a frame of reference for equipping American children "for the successful practice of democracy."

There were no special Federal funds made available for this conference, but some funds were secured from private sources.

In mid-January 1940, approximately 700 men and women gathered in Washington to consider the state of child life in the United States, the forces that shape it, and the conditions requisite to health and opportunity for all children. A few scattered young people sat in with the group as observers and commentators.

President Franklin D. Roosevelt in opening the Conference said:

> A succession of world events has shown us that our democracy must be strengthened at every point . . . if anywhere in the country any child lacks opportunity for home life, for health protection, for education, for moral or spiritual development, the strength of the Nation and its ability to cherish and advance the principles of democracy are thereby weakened.

The Conference ended with a "Call to Action:"

> Somewhere within these United States, within the past few years, was born a child who will be elected in 1980 to the most responsible office in the world, the Presidency of the United States . . . . If we could unroll the scroll of the future enough to learn his name . . . how many things we would wish to have done for him, how carefully we would wish to guard his healthy growth . . . . What we might wish to do for that unknown child . . . we must be ready to do for every child, so he may . . . live a full life, satisfying to himself and useful to his community and Nation.

Nevertheless, the Conference report presented statements of principle rather than a program for definite action. The report called on the family, as the "threshold of democracy," to supply democratic principles not only within itself but also in relationships with others.

Throughout the report recurred recommendations for further study, for strengthening personnel and training standards in health and welfare services, for financial assistance to families in need, and for administrative improvements in services.

Within a few months after the Conference, followup activities had been begun in a number of States, but National and State committees were soon engulfed in national defense and wartime activities.

### *Midcentury Conference (1950)*

The Midcentury White House Conference on Children and Youth was concerned with democracy's great responsibility to "produce socially minded, cooperative people, without sacrificing individuality." A growing interest in mental health made a careful appraisal of the requirements for healthy emotional development a natural focus.

The Conference was supported primarily by voluntary funds. Congress made an initial appropriation to get the Conference underway.

Over 5,000 delegates from every State and Territory in the United States and several foreign countries attended the Conference held December 3–7, 1950. Other countless thousands were reached through radio and television. Five hundred of the delegates were young people 12 to 23 years of age. They came as members of the Conference's Advisory Committee on Youth Participation, as representatives of national voluntary organizations, and as members of State delegations.

Working as members of Conference committees, cooperating agencies, State and local committees, or youth commissions for more than two years, the participants had gathered facts about children's needs, surveyed local conditions, pulled together available knowledge about child development, and otherwise contributed to a store of written material assembled in preparation for the Conference.

A youth delegate gives his views on one of the recommendations proposed at the last session of the 1950 White House Conference on Children and Youth, in which each recommendation was debated before a vote. This session lasted for 9 hours.

Every State and Territory and 1,000 counties had these White House Conference committees. Over 100,000 citizens contributed to their work. Thirty-seven units of the Federal Government brought together a picture of their services for children. Research workers and students from over 150 universities, foundations, and other centers helped in surveying what was known about how healthy personality development is achieved. The members of the Conference were presented with four printed documents representing a synthesis of this accumulation.

President Harry S Truman set a grave tone for the Conference when he warned:

> We cannot insulate our children from the uncertainties of the world in which we live or from the impact of the problems which touch us all . . . . What we *can* do . . . and must do—is to equip them to meet these problems, to do their part in the total effort, and to build up those inner resources of character which are the main strength of the American people.

Major responsibility for nurturing healthy personality, it was agreed, rested with parents, but all institutions and individuals touching the lives of children and youth had a part to play in creating a conducive environment. This, it was pointed out, called for more and better trained professional workers—workers trained not only in their own specialty but also in an understanding of personality development.

The conferees concluded that knowledge of children's needs was far from definitive, and that this posed a major problem to the practitioner who "must attempt to apply as a whole that which comes to him in segments." But, they decided, "there is plenty of knowledge to do an infinitely better job than is being done today."

A platform and 67 recommendations for meeting the problems which prevent children and young people from achieving healthy personality were adopted by the delegates after considerable debate and voting on each item in a final plenary session.

For the first time in the history of the White House Conferences on Children, followup committees survived and functioned during the entire period between Conferences.

Shortly after the 1950 Conference, the National Midcentury Committee for Children and Youth was formed to publicize its findings, promote action on the 67 recommendations, and to encourage further research. This Committee carried on its work until 1953 when it dissolved.

This left another Conference product, the National Council of State Committees for Children and Youth, representing 51 State and Territorial committees, without a central information exchange. To bridge this gap, the Federal Interdepartmental Committee on Children and Youth agreed to provide the Council of State Committees with staff service. Four times in the past decade—in May 1954, December 1955, December 1956, and March 1958—the Interdepartmental Committee, the National Advisory Council, and the Council of National Organizations (a coordinating body of 464 national voluntary organizations) have met together to review the needs of children.

After the Conference, many of the States held "little White House Conferences" called by their Governors to discuss its findings. Some of these drew well over a thousand people.

As a result of the findings, services for children were reviewed, modified, and extended in many communities, and the legal bases for services to children and their parents were reexamined and modified in many States.

Conference materials were disseminated widely—and continue to circulate. They have appeared in scores of textbooks for high school and college students. A book for technical workers, "Personality in the Making," by Helen Witmer and Ruth Kotinsky, appeared in 1935.

On May 17, 1954, the Supreme Court of the United States in its decision outlawing racial segregation in public schools cited the findings of the Conference's Fact Finding Report on the harmful effects of segregation of children.

The Children's Bureau added to its list of "best sellers" a publication entitled "A Healthy Personality For Your Child," a popular version of the Conference's Fact Finding Digest. Well over a half-million copies of this pamphlet had been sold by the Government Printing Office by August 1959. A discussion aid issued in connection with this pamphlet has been used by many hundreds of parent education groups.

The various professions—social work, nursing, public health, medicine—have incorporated Conference findings in their training undergraduate and graduate programs and in institutes and refresher courses for people on the job.

All of this adds up to persuasive evidence in many areas that children are better understood than before the Midcentury White House Conference and that this understanding will spread and deepen in the years ahead.

### *Conferences in Perspective*

Plans are already underway for following up the findings of the Conference to be held next March. [See p. 34.]

As a Nation, we have come a long way since the first White House Conference on Children in 1909 in safeguarding and advancing the well-being of children. Progress has been made despite hot and cold wars, a depression, enormous expansion, and change.

Perhaps history will show that the greatest contribution of these Conferences has been keeping the channels of communication open between the specialists, research workers, practitioners in services for children, and parents and other citizens.

Fortunately this river of ideas has had currents moving in both directions. Ideas for the betterment of children and child life have flowed from neighborhood groups to local and State committees and on to the national conference—and then out into the programs, practices, and vistas of many organizations and agencies. The force of this flow has done much for the coming generations of children, for their parents, for communities, for our democratic country, and for children round the world.

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And when one of you falls down he falls for those behind him, a caution against the stumbling stone.

Ay, and he falls for those ahead of him, who though faster and surer of foot, yet removed not the stumbling stone.

*Kahlil Gibran in* The Prophet.

# CYSTIC FIBROSIS AND FAMILY STRESS

DOROTHY H. ANDERSEN, M.D.

*Attending Pathologist and Assistant Attending Pediatrician, Presbyterian Hospital, New York*

CYSTIC FIBROSIS of the pancreas, or mucoviscidosis, is a relatively common congenital disease which was almost unknown 20 years ago. At that time most patients afflicted with it died in infancy from malnutrition and bronchopneumonia, and the underlying disease was unsuspected. Since then, knowledge of cystic fibrosis has increased. With the aid of earlier diagnosis and informed therapy, life has been prolonged in most cases to childhood and in some to adolescence or early adult life. As a result there are increasing numbers of surviving children and young adults with fibrocystic disease who present many new problems not only to their physicians but also to their families and communities. Their survival has also made it apparent that cystic fibrosis may have many clinical forms in older children and adults.

Although cystic fibrosis is well known to pediatricians, it often goes unrecognized by other physicians. A brief description of the disease is not easy to provide. Many or perhaps all of the exocrine glands function abnormally. The exocrine glands are those which pour their secretion by some route to the outside of the body, in contradistinction to the endocrine glands which empty their product into the bloodstream. In cystic fibrosis the exocrine glands chiefly affected are the mucous glands of the bronchi and nasal passages, the sweat glands, and the digestive glands. To make the matter more complex, these glands are affected in somewhat different ways.

**Digestive glands.** Many of the digestive glands, including those of the pancreas and intestinal tract produce a thick secretion which may congeal like overly thick gelatin, blocking the ducts which drain the secretion into the intestinal lumen and sometimes blocking the intestine itself. The name cystic fibrosis of the pancreas derives from the distinctive microscopic appearance produced in the pancreas, with ducts dilated and surrounded by scars.

When the pancreas is not functioning, digestion is impaired, and much of the food passes through the body unused. In a child with cystic fibrosis who is receiving a normal diet, about 50 percent of the fat and protein and about 15 percent of the carbohydrate ingested can be recovered in the feces. Fat-soluble vitamins are lost with fecal fat, resulting in deficiency of vitamins A, D, K, and E.

Most older children with the disease compensate for their inefficient digestion by eating hugely; however, infants are often unable to compensate, even if fed as much as they desire. Slow growth, a large appetite, and bulky stools are features of cystic fibrosis which result from the pancreatic dysfunction.

About 10 percent of all infants with the disease are born with intestinal obstruction because of abnormally thick meconium, due to abnormal secretion of glands lining the intestine. The infants with this condition are said to have meconium ileus, and few of them survive the necessary surgical procedures. When they do survive, their later course is similar to that of other patients with cystic fibrosis.

**Mucous glands.** The abnormality of the bronchial mucous glands is less well understood. Normally, bronchial mucus functions as a snare for catching inhaled particles of dust and bacteria. The mucus is then transported by waving cilia up the bronchi and trachea in a manner suggesting a belt conveyer.

Based on a paper presented at the 1959 annual meeting of the American Public Health Association.

As reported previously in CHILDREN (January-February 1959, page 36, and July-August 1959, page 155), the Children's Bureau and the National Office of Vital Statistics in cooperation with the National Institute of Allergy and Infectious Diseases have for the past year been bending efforts to learn more about the incidence of the frequently unrecognized genetic disease, cystic fibrosis of the pancreas. The first stage of the project, a sampling of 616 hospitals, indicated that more children under 15 may die from this debilitating disease each year than from diabetes, rheumatic fever, or poliomyelitis. The second stage of the project, a survey of cystic fibrosis patients known to hospital outpatient departments serving children and to a sampling of about 1,000 physicians in private practice (including all the pediatricians) in three New England States, is now in process as a preliminary step in developing a design for a national survey.

Nine States report inclusion of cystic fibrosis among the conditions for which diagnostic and treatment services are available through their Federal-State programs of crippled children's services.

When the mucus reaches the upper trachea it is coughed up. In children with cystic fibrosis this process is impaired, probably because the mucus is abnormal, so that the children have difficulty in clearing their bronchi.

The bronchi then becomes obstructed with mucus and pus, the lungs become overexpanded and emphysematous (having an abnormal number of air spaces), and the chest develops a barrel shape. Susceptibility to bronchitis and resulting chronic lung disease is characteristic of patients with cystic fibrosis. Each fresh respiratory infection increases the pulmonary changes. As a rule, only relatively common and benign bacteria can be cultured from the bronchial mucus: for example, a Staphylococcus aureus, Pseudomonas aeruginosa, and Proteus vulgaris.

Sweat glands. The sweat glands are affected somewhat differently. Although they appear normal under the microscope, their function is abnormal. The sweat of persons with cystic fibrosis contains excessive amounts of salt. Moreover, the salt content of the sweat does not decrease in hot weather as it does in normal people, so that large amounts of salt may be lost from the body. As a result persons with this disease easily develop heat prostration if they do not receive extra salt during hot weather.

The determination of the sodium and chloride in the sweat is a simple procedure and is our most valuable means of diagnosing cystic fibrosis. The parents and siblings of children with this disease often have a moderately elevated sweat salt, a fact of importance for study of the genetic pattern.

The most common clinical results of cystic fibrosis are, therefore, chronic bronchitis, malnutrition or poor gain, steatorrhea (fatty stools) with loss of fat-soluble vitamins, and susceptibility to heat prostration. The respiratory infection produces the most distressing symptoms and is the usual cause of death.

### *A Case Illustration*

The clinical picture presented by individual patients varies according to the glands chiefly affected and is also influenced by the type of therapy provided. The following story of Jane exemplifies the most common form of the disease.

Jane was the third child of healthy parents. The first child was born with intestinal obstruction and died in infancy the week following operation. The parents were told that this baby had had meconium ileus but were not warned that their later children might also be physically abnormal. Their second child was normal.

Jane appeared normal at birth but gained only slowly in her first 2 months in spite of a good appetite and normal activity and development. She then did well until her fifth month, when she developed bronchopneumonia; this responded to chemotherapy. At 8 months she again had bronchopneumonia, which responded to therapy only in part. Thereafter she had a chronic cough and wheezing, failed to gain normally, and developed a potbelly.

Jane was seen by three physicians. The first made a diagnosis of pertussis and the second of asthma. The third, recognizing the possibility of cystic fibrosis, established the diagnosis by the sweat test and the finding of excess fat in the stool. He referred the child to a children's hospital for confirmation of the diagnosis and for therapy. She responded well to the initial course of therapy, but was found to have extensive pulmonary changes.

Jane's family was informed of the familial nature of the disease and instructed as to her diet, vitamins, added salt, and antibiotic therapy. After 3 years

during which the child's cough was moderate and her gain slow but progressive, she developed measles and died a few weeks later.

### *Origin and Incidence*

Cystic fibrosis belongs in a group of hereditary metabolic diseases. As far as is known, only the exocrine glands are directly affected. The children are of normal intelligence, attractive, and without malformations in the usual sense. The genetic pattern is not yet clear. The disease occurs among siblings with the frequency of a recessive trait. Sex distribution is equal. Occurrence of the disease bears no relation to the age of the parents, the sibling order, or the economic status. All cases so far reported have been in the Caucasian race in various parts of the world and in the American Negro.

We do not yet know whether cystic fibrosis is transmitted through a dominant or a recessive gene. Although occasional cases are seen among cousins and more distant relatives, these are less common than would be expected if the gene were a Mendelian dominant. On the other hand, consanguinity is rare in families in which this disease occurs, while it is common in the families of persons with traits known to be transmitted by recessive genes. It has been calculated that if cystic fibrosis is caused by recessive genes, 1 in 20 of our population carries the gene. This seems improbable. Whether the gene is dominant or recessive, its manifestation is irregular in penetrance and expression.

The basic metabolic defect which is inherited and which affects the various glands is as yet unknown.

Cystic fibrosis has been estimated as occurring in about 1 per 1,000 live births, a frequency about half that of erythroblastosis foetalis (anemia of the newborn caused by Rh factor incompatibility between mother and fetus). The number of living cystic fibrosis patients of all ages is far less than might be expected from this figure because of the high mortality in early life.

No accurate figures exist as yet on the number of persons with cystic fibrosis who are now living or on the number of deaths from the disease per annum. A study to determine the incidence of the disease is now being made by the Children's Bureau and the National Office of Vital Statistics. [See CHILDREN, July–August 1959, page 155.] In a preliminary report last April it was estimated that in the year 1957 there were 2,500 hospital discharges with this diagnosis, and of these one in seven was the result of death.[1] The Babies Hospital in New York sees 50 to 60 new cases per year and is following over 250 cases, while the Boston Children's Hospital sees about 100 new cases a year. Many patients in both clinics are referred from other cities. These figures only tell us that the disease is far from rare.

### *Family Stresses*

Cystic fibrosis has become a public health problem because of the great, often devastating, strain which it places on the many families involved. These families need help of all kinds, financial, medical, educative, and supportive. The pressure and anxieties resulting from cystic fibrosis in the family may be grouped into three categories: (1) those directly concerned with the care of the patient; (2) the financial stresses; and (3) the problems presented by the disease's hereditary nature.

First, the immediate care of the patient requires supervision by a doctor or clinic familiar with the disease, able to instruct the mother, and able to provide her with continued emotional support. At home the child needs daily vitamin supplements, salt tablets, and usually antibiotics of some sort. He does better on a planned diet, which the mother must learn how to prepare.

The mother of the child with cystic fibrosis has many difficult decisions to make. Can Jim play with other children? Is isolation or exposure to infection the greater risk? How much exercise can the child stand? Will other mothers fear that his cough means a contagious disease? Shall he go to school or have home teaching? Can he go swimming? (The answer is yes.) How can his condition be explained to his grandparents and to the neighbors?

The child himself, as he grows older, learns that he is different from other children. He may also learn that many children with cystic fibrosis die before they grow up. As he reaches adolescence he has new worries. What kind of work will he be able to do? Should he marry? How long a life should he plan for? With these problems added to the usual strains of adolescence, it is not surprising that some adolescents with this disease become deeply depressed.

The financial problems are staggering. Hospital bills are usually covered only in part by hospital insurance. Even if the child escapes hospitalization, the cost of his illness adds an estimated $1,000 to $1,500 a year in druggists' bills, X-rays, trips to the clinic, high protein foods with plenty of meat. Families of moderate income sometimes deprive the rest of the family of protein foods so that the sick child may have enough. Some sell their homes to pay the

bills. Many parents who can see little improvement in their child from all the other measures they have taken decide to move their family to another climate, often at financial sacrifice and usually without benefit.

The genetic implications of the disease present other problems. The most pressing for the parents is often the question of whether or not to have more children. Shall they take a chance, and have other children of their own? Or shall they adopt a child, go in for artificial insemination, or perhaps get a divorce and begin over again? Sometimes the two sets of grandparents come into the conflict, each set convinced that the bad inheritance must come from the other.

Finally, many families feel isolated by what seems to them a unique problem, and many feel resentment because of the delay in diagnosis which resulted from their doctor's lack of knowledge about the disease. Many have been frustrated in their attempts to obtain assistance from public agencies to meet the heavy burden imposed on them by the disease.

### *What Can Be Done*

What can be done toward solving these problems?

1. **More research.** The first need is for more knowledge, more research into all aspects of the disease.

2. **Dissemination of knowledge.** The knowledge that we have is not well disseminated among physicians, schools, or even public health agencies. Recent medical school graduates and pediatricians are the best informed groups, but many other physicians know little more about cystic fibrosis than the name. If the public health center, the school nurse, the social service agencies, and the general public knew a little more about the disease, the families with affected children might be better provided with counsel and support. In large centers of population a counseling service for the increasing number of adolescents and young adults having cystic fibrosis would be invaluable.

3. **Public aid.** Third, much of the family's financial burden could be borne by public aid. In Connecticut, for example, the cost of drugs and vitamins is assumed by the State. However, in many States the laws exclude cystic fibrosis from the group of diseases supported by State funds.

A start has been made toward solving some of these problems. The National Cystic Fibrosis Research Foundation, organized by the parents themselves, is working effectively at raising funds for research and education. The Public Health Service is in process of starting a research group at the National Institutes of Health. The cystic fibrosis clinics of a number of children's hospitals across the country are absorbed in medical care of patients and in basic research, usually without adequate support.

Awareness of the disease is becoming more widespread. This will, we hope, result in effective action toward solution of the medical and social problems resulting from cystic fibrosis.

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[1] Sirken, Monroe G.; Crane, Marian M.; Brown, Morton L.; Kramm, Elizabeth R.: A national hospital survey of cystic fibrosis. *Public Health Reports*, September 1959.

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This problem [illegitimate children on assistance rolls] will be met effectively only as we are willing to travel down the long hard road of elimination of slum areas, of strengthening of our total program of education, of strengthening family life, and above all of strengthening the spiritual foundations of this Nation. I just don't believe that an effort to find a short cut by the use of punitive measures directed against children will solve the problem any more than our forefathers solved the problem of indebtedness by putting debtors in jail.

*Arthur S. Flemming, Secretary of Health, Education, and Welfare, before the Governors' Conference, San Juan, Puerto Rico, August 4, 1959.*

*A psychologist finds some implications for health and welfare efforts in . . .*

# MODERN THEORIES OF COMMUNICATION

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AMONG THOSE who are engaged in promoting the health and welfare of the Nation, successful educational communication with the public at large or with specific population groups is essential. For some of these, indeed, such successful communication is the very core and purpose of their activities; and they often look to the experts, particularly the behavioral scientists, for help and advice on ways of improving their effectiveness in these activities.

This article will focus on a few principles from behavioral science of which the implications for effective communication have not been widely appreciated. These principles have been selected because of their relevance to the activities of professional persons who must communicate with large, dispersed population groups with whom they normally have little or no personal contact.

Before proceeding, one issue should be considered. Communication could be regarded as a process, the sole purpose of which is to transmit information from one person or group to other persons or groups. However, the flow of communication to the public from professional persons concerned with public health and welfare is intended more often than not to bring about some change in people's behavior. Sometimes this is quite clear from the tone and content of the material that is being communicated. At other times, this purpose is not so apparent. Thus, much, and probably most, communication that goes from health and welfare agencies to the public via radio, TV, newspapers, magazines, lectures, pamphlets, and the like, although apparently designed merely to give the public factual information, is really aimed, deliberately or implicitly, at affecting people's behavior in one way or another. For this reason, communication will be treated in this article as a process by which we attempt to influence and modify behavior rather than one by which we merely disseminate information.

Undoubtedly, to be able to act intelligently, people must have available to them pertinent information on the basis of which they can make decisions as to what they should do, and how, when, and where to do it. However, there is ample evidence that the frequently made implicit assumption "if we only inform the public, they will act in a way that we consider desirable," is fallacious. Such evidence points to the conclusion that while information is often one of several *necessary conditions* for rational behavior, it is rarely sufficient by itself to *produce* it.[1,2]

### *Made To Fit the Audience*

One other necessary condition for a communication to be effective is that it fit into the already existing framework of attitudes, interests, and needs of the people whose behavior the communication is to affect. When an attempt is made to communicate

Based on a paper delivered at the Seminar on Communication in Public Health Education Practice, School of Public Health and Center for Continuation Study, University of Minnesota, June 1959.

to a person something which is of no great concern to him at the time, he may fail to become aware of the communication or, even if he does, he may reject its content. If the communication does relate to something that is important to him but clashes with his present needs and motives, he may unconsciously modify it in the process of adapting it to his present pattern of beliefs. In short, communications tend to be perceived and interpreted by a recipient in terms of his own stereotyped perceptions, his own needs, and his own desires.

In order to assure effective communication, then, one must *know* and take into account the needs and problems, motivations and fears, customs and norms of the people to whom one is trying to communicate and then adjust the form of the communication to their cultural milieu.

We give frequent lipservice to this principle, yet may become so engrossed in our own ideas as communicators that inadvertently we judge the likely success of our messages in terms of our own reactions to them. Hence, we may fail to consider the possibility that the people in our intended audience may react quite differently because they look at the subject from a different point of view. We may forget that what is important, interesting, and meaningful to us as health educators, teachers, physicians, nurses, and social workers may not be important, interesting, or meaningful to other members of the public.

To avoid this we must carefully adapt our messages to the existing beliefs and attitudes of the people with whom we wish to communicate. If we succeed in this we are likely to discover a readiness to accept and learn from our communication.

### *Proper Timing*

Since such readiness to learn may fluctuate in response to various events, proper timing of communication can become very important. A favorable condition may exist, for example, when a person finds himself in an acute crisis which disrupts his accustomed order of things and when he faces an unaccustomed and threatening situation. At such a time of uncertainty and insecurity, the person has a deep need to regain a grasp on something firm—anything firm. And it is this need that may make him highly persuasible. The need for information is very intense and communications made during this period of persuasibility may be eagerly accepted, learned, and used.

In fact, there is some danger that the same emotional dynamics which generate such a need in a moment of crisis may also tend to rob the person of his ability to discriminate between rational and irrational solutions to his problems and to inhibit his judgment as to the soundness of his sources of information. Hence, the identification of such teachable moments or periods is significant not only because they offer an opportunity for effective education, but also because they present a danger that the person may satisfy his need by turning to improper sources of information when sound sources are not available.

Examples are plentiful. Never is a man more eager to learn about heart disease than when he has suffered a heart attack. However, illness is not necessary a prerequisite. For instance, the period of adolescence, the transition from the accustomed security pattern of childhood to a new world of adulthood, is one during which the boy or girl is most receptive to all sorts of influences.

We can conceive of "teachable moments" as existing for communities and whole populations as well as for individuals. Thus the nationwide state of excitement existing after the 1956 public pronouncement that the Salk vaccine was safe and effective very likely presented a propitious opportunity for educating the public in regard to the general protection of their children's health. Instead of focusing solely on the fact that a new vaccine was now available for *doctors* to use against a specific disease, more intensive educational efforts through newspapers, magazines, discussions at PTA meetings, and other means might have been made to create in the public the idea that *parents* could now broaden the scope of their efforts to safeguard their children's health. The securing of polio vaccination for their children might have been presented as one among other advisable steps toward disease prevention—immunization against other communicable diseases, the provision of proper diet and sanitary conditions in the home, the support of movements for water fluoridation, and so forth. Thus the widespread interest in the Salk vaccine might have been used as a stimulus to arouse interest in good health practices in general.

Since, however, we cannot always wait for the occurrence of events which would create such a widespread readiness to learn among population groups, we might try to stimulate through subtle means a similar climate conducive to learning. Let us say that in a particular town the health unit plans an immunization program for a date 2 months hence. The unit might during these 2 months arrange to

publicize through various media of communication as many references as possible to the disease against which the immunization is designed to protect. The messages should be nonthreatening and should aim at arousing interest rather than at imparting information or at producing any action; that is, they should create a subtle but widespread level of awareness and interest in relation to the disease and to protection against it.

If skillfully carried out, such an approach might succeed in building up a readiness in people to respond positively when the time comes to appeal for actual participation in the immunization program.

### *Post-action Learning*

A readiness to learn seems to exist in a person just after he has carried out some action that fits in with the ideas we wish him to learn. Suppose a man is not really opposed to going to a physician for a routine checkup but, on the other hand, feels no particular need for it, and perhaps even thinks it somewhat silly and superfluous. Suppose, further, that in response to his wife's nagging, he finally visits a doctor. Recent research suggests that after having carried out this action, he will tend to grope unconsciously for good, intelligent reasons to justify his original decision. He may become convinced that he went to his doctor because he is a mature, rational being, concerned with maintaining his health to protect not only himself but also the welfare of his family.

This man is not deliberately falsifying what happened. He becomes actually and sincerely convinced of this new interpretation; his wife's nagging has receded into the forgotten past or is seen as having had no crucial bearing on his decision to visit his doctor.

This reaction, of course, does not always happen, or at least not always exactly in this manner. However, there is evidence[3,4,5] that people right after having taken an action tend to be very susceptible to communications which will supply them with a rational and desirable underpinning for the action.

Let us say a small group of adolescent girls discusses the pros and cons of smoking and decides unanimously to wait a while longer before beginning to smoke. The temptation may exist for their teacher to view this group decision as a desirable solution of the problem for the present and to forgo or postpone any further education in regard to the health hazards of smoking. This would miss a most promising opportunity.

Probably, despite the apparent unanimous decision, different shades of conviction exist within the group. Some girls may have gone along with considerable resistance; and perhaps even in those who were most vocal against taking up smoking, the conviction may not have been without some inner doubt. However, at this time—shortly after their vote against smoking—all the girls are likely to be quite receptive to reinforcement of the reasons that prompted them to take this action. The teacher could be very successful in removing doubts and strengthening convictions by skillful utilization of this opportunity.

But suppose that the girls had decided that they would like to start smoking now. In this case, the same dynamics would tend to function. If the girls were exposed to any communications, say by other adolescents or through TV or radio, such communications might confirm their decisions to smoke by furnishing them with additional reasons for wanting to do so.

### *Followup of Communications*

Learning and motivation stimulated by a communication tend to level off with time. The content of a message may become partially forgotten or distorted, and the motivation it aroused may dissipate, sometimes rapidly. Therefore, wherever possible, the opportunity to take a recommended action should be provided while motivation is still close to the peak, that is, as soon as possible after the communication which advocates the action.

For example, in a session in which the value of polio vaccination has been discussed, the full impact of the educational effort is utilized when members of a group can sign up for shots immediately following the discussion. Any delay is likely to result in loss of motivation and, therefore, in decreased participation. Furthermore, as has been mentioned, an action carried out voluntarily for reasons which the individual perceives as good tends to strengthen his belief in these same reasons, particularly when such acceptable reasons are made explicit at the time. Clearly, a close temporal link between educational effort and opportunity for related action makes repetition of the action more probable and also is likely to lead to more profound and more lasting motivation and learning.

Where this temporal link is not possible, dissipation of any stimulated motivation and learning with the passage of time may be prevented by judiciously spaced followup communications which would serve

to keep alive and even to strengthen the original.

In short, disconnected random communications or educational efforts can be expected to be less effective in the long run than a continuous well-planned and well-integrated program where each message is based on previous messages, reinforces them, and in turn provides a basis for subsequent messages.

### *The Role of Anxiety*

Because anxiety and fear are emotional states that are easily aroused, and because of their motivating power, they have been extensively used by persons who wished to change or direct the behavior of others. In areas in which people are especially concerned, such as health, child rearing, and pregnancy, the temptation to motivate by producing fear has been exceptionally great.

There has been much research on the role of anxiety in communication.[6] Many questions remain unanswered. Still, a few points stand out clearly. Fear is indeed one of the most powerful motives affecting human behavior. We have learned, for example, that people who feel no concern about a specific health threat—that is, are free of any anxiety—not only are unlikely to heed communications concerning this health threat and to learn from them, but are equally unlikely to take any voluntary action to safeguard their health in respect to it.[4,7]

However, the use of anxiety can easily backfire. A number of experiments[6] have produced evidence that while a slight increase of anxiety or fear is associated with more learning, extreme anxiety may have the opposite effect. In addition to the agonies of severe anxiety, deep and intolerable inner conflicts may be created. The individual may try to resolve this situation in all sorts of ineffectual and sometimes pathological ways, such as denying even to himself that any threat exists. Such results obviously defeat the purpose of the educator who had hoped to use his appeal to fear as a lever to create a readiness for learning and for constructive behavior change.[5,6]

### *Mass Media of Communication*

In our society, the principal means of communicating to the public are the mass media—radio, TV, newspapers and magazines. These media are undoubtedly tremendously effective in spreading information to large numbers of people. They are undoubtedly also tremendously effective in stimulating persons already interested and motivated to translate their motivations into action. However, they tend to be more successful in channeling already existing motivations into specific modes of action than in creating new motivations.

Programs to educate the public cannot afford to neglect the use of mass media, but neither can they afford to rely entirely on them for communication, for the mass media possess some inherent shortcomings and even risks. One of the risks derives from an often overlooked characteristic of persons who are anxious. The anxious person looks more for assurance than for facts. Though he may ask for information, it is not so much information per se that he wants as it is the emotional support he may derive from the interaction with others in the process of obtaining it.

The anxious person wishes not only to receive communications, but also, because of his anxiety, to communicate with others. The opportunity for mutual communication is most frequently provided in informal exchanges with relatives, neighbors, and others with whom he has personal contacts. The mass media cannot provide this two-way flow of communication, this interaction which is of such great importance in the learning process of the anxious and worried. This is their most crucial weakness in regard to subjects about which fear and anxiety are intensive and widespread.

The mass media possess limitations even where anxiety may play a less important role. If, as seems indicated, they are relatively ineffectual with those segments of the population who lack both the interest and the motivational and attitudinal framework which would make them likely to perceive and to be responsive to messages transmitted through them, other means must be found to reach such groups. Learning does not usually take place through passive exposure to communication, especially if such learning entails fairly drastic modifications of established habit patterns or if it runs counter to the cultural and social norms in the social milieu of the communicatee.

Obviously—though this does not always seem to be recognized—any communication aimed at total populations cannot take into account the special and unique needs, beliefs, and habits of minorities and other subgroups within the population. Especially in areas in which personal and group investments are strong and emotional, in which values are deeply ingrained and subcultural norms are powerful, communications aimed at one segment of an audience may easily have an effect on other segments of the same audience that is very different from and perhaps

diametrically opposed to the effect that is desired.

For these reasons the purposes of a program of public education are not likely always to be furthered by simply increasing the flow of communication from radio, TV, magazines, and newspapers. The use of mass media has to be augmented, and at times supplanted, by the use of the slower and more tedious processes of individual contacts and group interaction.

That this is so is probably recognized widely, and in some professions it is the basis of their operations. Yet, when the need arises to educate larger population groups, the principal recourse usually is still the mass media of communication.

### *Persuasion versus Education*

The use of the mass media appears to be both easy and economical in the long run. Furthermore, posters, radio messages, or TV spots are obvious and striking signs of the educator's activities, while efforts on the individual and group levels may remain relatively obscure. In addition the effects of mass media are often more demonstrable. For example, appeals through these media may bring large numbers of people to disease-screening units while the painstaking and time consuming work in homes, schools, and meeting halls may appear to bring only small returns.

To the extent that the avowed purpose of a communication or series of communications is simply to induce people to take a given action, the criterion of success may well be the number of people taking the action. If, however, the purpose of the communication is one of educating the public or certain defined groups in the general population toward the development of attitudes and behavior that are more likely to assure them maximum health, welfare, and security, then other considerations become important.

For example, health education as a broad movement is, I believe, concerned primarily with two major objectives. One is to provide the public with the *information* and the *understanding* they need to make sound decisions concerning what kinds of health actions to take and when and under what conditions to take them. The other, of equal or even greater importance, is to stimulate the public to become *interested* in principles of good health and to motivate people to face health problems intelligently, to make rational decisions concerning such problems, and to *follow them up* with appropriate effective action.

It is perhaps unavoidable, but certainly unfortunate, that frequently there is an exclusive concentration on attempts to motivate the public to take highly specific health actions, be it to obtain polio shots, visit the dentist, prepare proper diet for the family table, or fluoridate the water supply, with a corresponding neglect of efforts to keep the broader objectives of health education in mind.

Concentrating on the stimulation of as many people as possible to take specific actions rather than on education of the public toward an understanding of the principles underlying such action may have deleterious effects.

To illustrate: For years the public was bombarded with messages designed to persuade them to obtain chest X-rays for tuberculosis case finding. They were told to get an X-ray every year or every other year. Suddenly, in the light of what was learned about radiation danger, the methodological approach to case finding in tuberculosis was revised.

Many people undoubtedly had learned the *broad principles* underlying tuberculosis screening: (1) a person may have tuberculosis without being aware of it; and (2) if through proper means the disease can be detected before it progresses too far, prognosis is much better. For these people, the shift in emphasis from one technique of early detection (chest X-ray) to another (such as tuberculin testing) is simple enough and requires no change in their perception of the principle of case finding, and they are likely to make the transition without much ado or disturbance.

On the other hand, there were undoubtedly many people who had not learned the principle but had merely regarded the *act of being X-rayed* as something that would be good for them in relation to the disease. These people may interpret our new approaches to tuberculosis case finding as a total reversal in policy. They may have to relearn their entire concept of how to protect themselves against the disease. Not only is *re*learning more difficult to accomplish than original learning, but the process may arouse suspicion and doubts about the reliability of communications from public health organizations.

Since broad principles tend to change much less in a given period of time than specific techniques, we take less of a chance of having today's communication seem to contradict tomorrow's if we make all possible efforts to educate the public in terms of the relationship of the single desirable actions to such broader underlying principles.

There is another good reason for teaching principles. As has been mentioned, people are more receptive and responsive to communications which are



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congruent with their opinions and perceptions and so can be easily absorbed into their already existing attitudinal and motivational framework. To the extent to which we succeed through education in helping the public develop better understanding of broad principles together with a favorable attitudinal and motivational framework, to that extent future pertinent communications are likely to fall on more fertile ground.

Obviously there are considerable difficulties inherent in such attempts. There are several drawbacks as well. If we wish people to understand principles, we want them to think. And their thinking may not have the results we the educators desire. In other words, people may draw different inferences from our principles than we would like them to draw. But this is a chance we may have to take: where education truly succeeds, it creates in the educated the intellectual and motivational potential to disagree with the conclusions being communicated to them.

Allport [8] has said: "We are habitually tempted to present to our students and clients . . . summary statements of our hard-won conclusions . . . hoping thereby to bring our audience rapidly to our own level of knowledge. . . . The sad truth is that no one learns from having conclusions presented to him."

A primary lesson from all the foregoing may be this: In our attempts at educating the public, we should utilize *all* kinds of available facilities to communicate effectively; and we should use *all* theoretical and practical knowledge available about communication and learning processes. At the same time, however, we will have to allow every individual and every group to whom we address ourselves to adapt our messages and our teachings to their own needs, motives, and customary ways of dealing with their problems of life.

A few years ago, an African physician expressed this very principle with deep conviction while discussing with a health official from the United States the kind of help Africa needed. He said:

**Please send us guaranteed seeds and let us plant them in the African soil and let the African sun shine upon them, the African rains water them, and the African people tend them, and you will be surprised to see what a wonderful plant comes from these seeds. It will be one which is typically African and although it will differ from other plants that you have seen before, it will be of particular use to Africa. Please do not send us potted plants.**[9]

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[9] Dr. Karefa Smart of Ghana in a personal communication to T. H. Butterworth.

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## A TEENAGER'S ADVICE TO ADULTS

Don't worry too much about your children. They are good kids and love you for trying to help them, but they are growing up and need your understanding rather than your ideas. This growing up is a new experience to them just as much as their growing up is new to you. . . . This is the key to their as well as your happiness—"A little love and understanding goes a long way." If anything, that's all they need.

*Bonita Naylor, age 14, in "ideas" enclosed in a letter to the President.*

*Indiana's health and welfare departments develop . . .*

# TEAMWORK FOR BETTER NUTRITION OF CHILDREN IN GROUP CARE

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GOOD NUTRITION is essential for all children if they are to have adequate physical energy and stamina, a good mental outlook, and opportunity to lead a normal active life. It is particularly important for the child who has been deprived of parents and home and placed in foster care.

Such children are especially susceptible to the eating problems which are symptomatic of emotional upset. In addition many of them come from homes where, because of financial deprivation or mismanagement, they received inadequate daily diets resulting in poor food habits. Some, with health problems such as diabetes or allergies, have got into the habit of eating the same foods day in and day out because nobody has taken the trouble to find them good substitutes.

In Indiana the State welfare and health departments have been working together for the past 12 years to see that children in group care receive attractive, well-balanced meals and to help the personnel of child care facilities to understand and deal with the eating problems many of their children are apt to present.

The program involves the closely integrated efforts of the welfare department's child welfare consultants and of nutritionists and sanitarians from the health department, working with the personnel of the child care facilities. It had its formal beginning in 1947 when the State department of public welfare, which has legal responsibility for licensing the institutions, issued the following regulation:

> Each children's home or child-caring institution and day nursery shall provide food of sufficient quantity and nutritious quality to provide for the dietary needs of each child. Dietary supplements shall be provided for each child in accordance with the recommendations of the physician responsible for health supervision of the child. In a children's home or child-caring institution where a trained or qualified dietitian is not employed, the services of a trained dietitian or nutritionist available to the community or a nutrition consultant of the State Board of Health shall be obtained periodically to consult with the personnel of the children's home or child-caring institution on the storing, preparation, and serving of food and the planning of menus.
>
> All milk and milk products . . . shall be obtained from sources approved by the State Board of Health.
>
> Methods of food handling and food service . . . shall meet the requirements and rules and regulations of the State Board of Health.

Since the issuance of this regulation the child welfare consultants and nutritionists have worked as teams, calling on the board of health's sanitarians when necessary, to improve the nutrition practices in all of the 69 licensed child-caring institutions and day nurseries within the State.

At the beginning of the program, the consultants of both agencies met together regularly to become better acquainted with one another's points of view and approach. Their first objective was to see that all child-caring facilities in the State provide the

right kinds of food in the proper amounts for the optimum growth and development of the children being cared for. From the beginning, however, they have been interested in seeing that the children not only have well-balanced, well-prepared meals, but also are eating in attractive surroundings, with tables and chairs of appropriate size, and that they are encouraged to eat and enjoy the food that is served.

### *Early Surveys*

During the first year of the program, the child welfare consultants and the board of health's branch office nutritionists visited the institutions together to review the nutrition practices. This joint visiting was particularly helpful to the nutritionist, for whom it provided an introduction by a person already acquainted with the facility's personnel. It was of benefit, also, to the welfare consultant, enabling her to become better informed about what was required of an institution in meeting the regulations pertaining to food service.

These first food service surveys revealed numerous problems. Only a few of the matrons and cooks knew how to plan meals that were suitable for the children of the age of those in their care. Generally the meals were more suitable for adults than for growing boys and girls. In many places meals were planned on a day to day basis instead of a week or two in advance.

The menus lacked variety and many showed poor, unattractive food combinations. Often they were short on vegetables, eggs, citrus fruits, tomatoes, and raw green cabbage or a similar food. In many places the children were receiving insufficient milk. Suppers many times consisted only of leftover foods. Too many highly seasoned foods were being served, as well as too many fried foods and hot breads. Often, the same menu was repeated week after week on the same day of the week. In many places, particularly in institutions caring for teenagers, meals were inadequate in regard to quantity as well as quality.

The surveys also revealed that the cooks in the institutions needed help with proper methods of food preparation, particularly in cooking vegetables and meats. These were often cooked far ahead of serving time, losing not only their nutritive value but also flavor and attractiveness.

Kitchen equipment in many places was not only inadequate, but, frequently, in need of repair. A number of the larger institutions were using home-sized equipment in place of the institutional type. Storage facilities generally were insufficient and improperly used. Dishwashing equipment was often inadequate and hot water in short supply.

The surveys also showed a need for improved sanitary practices in the handling of food and of kitchen and eating utensils.

In a number of the institutions the dining rooms were drab and gloomy. In a few, the children were not allowed to talk with one another at mealtime. In only a few did the matrons eat with the children and try to help them improve their food habits and table manners.

Following the completion of the food service surveys of all of the child caring facilities in the State, another joint meeting of child welfare consultants and nutritionists was held to review the problems and to outline the procedures to be followed in upgrading institutional nutrition practices. It was agreed that the nutritionists would give the following types of assistance to institutions and day care centers: an annual evaluation of food service as a basis for licensure; consultation service on food service problems; consultation service on plans for new or remodeled kitchens, pantries, and dining rooms and their equipment; group meetings for food service personnel.

### *Provisional Licenses*

Since the original food service surveys of the institutions, the child welfare consultants and nutritionists plan their survey visits separately. However, following each survey visit made by the nutritionist, a complete report of the visit is sent to the welfare department, along with the nutritionist's recommendation on the issuance of a full or provisional license. When the recommendation of a provisional license is made, both the nutritionist and the child welfare consultant discuss the area needing improvement with the institution's administrator and other appropriate personnel and in many instances visit the institution together to suggest ways of improving its food service.

An institution is permitted to have only two consecutive provisional licenses. If regulations are not met by the time the second one expires the license is temporarily withdrawn. When this occurs, the child welfare consultant continues to work with the institution and requests the assistance of the nutritionist when she notes signs of greater receptivity to this kind of help.

In a number of cases of institutions which have received only provisional licenses because of food

service problems, the child welfare consultant and nutritionist have together met with the institution's board of directors to explain the program and to point out what needs to be done in order to upgrade the institution's food service. These needs might include an increased food budget, the purchase of some institutional equipment, or repainting the kitchen and dining room. In the case of some tax-supported institutions, these visits have sometimes had to be made with the officials of a local court.

In providing food consultation service to any particular institution the child welfare consultant and nutritionist carefully coordinate their work. When there are numerous problems to be worked out, they visit the institution together. Otherwise the nutritionist may visit first, and later on the child welfare consultant makes a followup visit to see if the institution is following the nutritionist's recommendations. The number of individual and joint visits made each year depends upon the number and nature of the institution's problems and the particular needs of the institution's personnel.

Nutritionists from the State board of health are routinely asked by the department of public welfare to give assistance with planning and equipping kitchens for new child caring facilities and those about to be remodeled.

### *Group Meetings*

While a great deal of individual consultation by both the nutritionists and the child welfare consultants has been given to food service personnel since the program began, time for such individual consultation is necessarily limited. As a complement, therefore, the program has also included annual meetings for matrons, cooks, and interested board members of child caring facilities in the five branch areas of the State.

These meetings are planned by the child welfare consultants and nutritionists along with representatives of the institutions in the area in which the meeting is to be held. Their programs include discussion of the more common problems found during the visits to the institutions by the child welfare consultants and nutritionists.

The emphases in these meetings have been in the following areas: (1) menu planning and food preparation; (2) food buying ; (3) sanitation; and (4) feeding problems of children.

The nutritionists of the State board of health have led the discussion on menu planning and given demonstrations in the cooking of vegetables, meats, main dishes, and salads. Sanitarians from either the State board of health or local health departments have given talks on the various phases of sanitation. The child welfare consultants have led the discussions on feeding problems of children.

Mealtime in a day nursery. When wholesome lunches are part of a day care program children's chances for healthy development are enhanced. In Indiana the State departments of health and welfare have been working together to improve the nutrition of children in institutions and day care centers.

In these last discussions the child welfare consultants have pointed out the relationship of emotional upset and strange eating habits, which may take the extreme forms—especially on a child's first separation from his family—of refusal to eat at all or of cramming food into the mouth as fast as possible. The consultants have stressed the necessity of using sympathetic patience rather than insistence in dealing with children who express their emotional upset in poor eating habits and obstreperous dining room behavior. Such children, they have suggested, might by helped by being allowed to eat alone with the housemother for a few days or to eat what they want until they calm down and become more interested in their surroundings and what other children do and eat.

The value of these meetings is substantiated each year when the child welfare consultants and nutritionists have made inquiries about the next nutrition meeting. While meetings once a year are not a substitute for one-to-one consultation, they have proven to be of real value in helping food service personnel understand that others have the same kinds of problems as they and that there *are* new and better ways of food preparation. The very opportunity to get

away from their own kitchens and to eat someone else's good food has proved to have incentive value.

### *Results of Teamwork Approach*

The randomly picked records of a number of children's institutions and day nurseries indicate that the majority have made great improvements in the quality of their food service since the survey findings in 1947. At the present time, only 3 of the 69 licensed facilities are having difficulty in meeting the regulations. Many of the institutions have done much more than the food service regulation requires.

Following are some examples of the improvement which has been obtained:

At the beginning of the licensure program both the menus and kitchen equipment of a large institution caring for 200 children were very limited. The dining room was located in the basement and was dark and drab. The children ate in silence, which added to the depressed atmosphere. Since the first survey, this institution has not only had numerous consultations from the child welfare worker and the nutritionist but it has also undergone a change in administrators. Today it has a fruit and vegetable garden, the use of which has greatly increased the nutritive value of the children's meals. It also has more adequate kitchen equipment, which makes possible better food preparation and the serving of a greater variety of foods. The dining room has been redecorated in an attractive color and new tables and chairs have been purchased. The children are allowed to talk at mealtime and the houseparents try to help them improve their eating habits and table manners.

In another institution at the time of the first survey the meals did not meet the nutritional requirements of the children, and the dining rooms and kitchens along with the rest of the housing were inadequate. The food was poorly prepared and quite unattractive in appearance. Since then a new plant has been built which has been in operation for almost 2 years. The area nutritionist assisted in planning and equipping the kitchen and dining room, which are a pleasant contrast to the old one. The cook, who has been given help both on an individual and a group basis by both the child welfare consultant and the nutritionist, prepares the food well and attractively.

It has also been possible to improve the food service in the licensed day nurseries. Several of these carry on educational programs with the parents of their children and include nutrition as one of the topics. They report that parents have frequently expressed their surprise at how much better "Johnnie" or "Mary" has been eating at home since attending the nursery.

Thus in Indiana we have proceeded on the theory that upgrading the nutritional opportunities of children in group care is a responsibility of both health and welfare authorities. In our cooperative program we believe we have found an effective way of combining the efforts of child welfare workers, nutritionists, sanitarians, and the administrators and personnel of the child welfare facilities to this end.

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> . . . Who are the heroes of our time in this country? I personally have identified them in the photographs of frightened, brave little Negro children going to [a once all white] school . . . and their equally brave parents deliberately taking physical and psychological risks for themselves and their children to achieve something paramountly vital. It is they who by individual courage and determination are building a tremendous individual and corporate tradition to which they and their succeeding generations can look with a feeling of respect and honor and solidarity. One hears it said that the children are irreparably damaged psychologically by their experience. Maybe not. Maybe they are strengthened by the ordeal and their understanding of what is involved.
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> *Albert Mayer in the* Catholic Charities Review, *January 1959.*

# SERVICES TO NEGLECTED CHILDREN

ANNIE LEE SANDUSKY
*Consultant on Social Services to Children Living in Their Own Homes, Children's Bureau*

WE ONLY HAVE TO READ the newspapers to know that serious neglect and abuse of children by parents is all too frequent. Today hundreds of children pass through our juvenile courts and into foster care because of neglect or abuse. Many delinquent children are also neglected children. Social services for neglected or abused children and their parents are therefore a basic child welfare service that should be available in every local community throughout the country.

Social work experience has shown that many neglecting parents want help in learning to be better parents and can benefit from it. Public and voluntary child welfare agencies in a number of places have demonstrated that many parents can be helped to grow and improve in the care, protection, and guidance of their children. When this happens the child's own home is preserved and his family is strengthened; parents and children are spared the trauma of separation; the community has been spared the high cost of supporting children in foster care; and some children may be saved from future delinquent behavior or from some day becoming neglecting parents themselves.

Children suffering from neglect or abuse are brought to the attention of the agency through someone other than the parent whose acts or behavior jeopardize the child's well-being. These children arrive at the agency because of the community's concern for them. The conscience of the community has been outraged and its expectancy in regard to parental care violated.

Neglect or abuse of a child may be a symptom of many types of problems among parents. These include deep-seated emotional difficulties, immaturity, drunkenness, marital problems—to name but a few. The agency is not free to refuse to help families with such problems on the basis that "our workers are not equipped to deal with them." It must see what can be done.

Child welfare workers are learning from experience with such parents that, as Helen Perlman has said, "the whole of living may be benignly affected by the resolution of one problem and the restoration of balance."[1] Often when parents are helped to achieve success in one small area, major problems become less overwhelming.

The K family, consisting of Mr. and Mrs. K and five children ranging in age from 11 years to a few months, were referred to the child welfare agency because of gross neglect of their children. Living conditions were deplorable. The children were usually dirty and unkempt, and school attendance was poor. Work with the parents revealed marital difficulty to be one of the major problems underlying the neglect. Mr. K was about to leave Mrs. K for another woman.

While Mr. and Mrs. K were discussing their marital difficulties with the worker at their home, 8-year-old Jean came into the room quietly crying. When the worker asked what was troubling her, Jean came to the worker, put her head on her shoulder and sobbed. She finally said, "I want to live with grandma." The worker asked Jean if she was worried about things at home and the child replied that she was. When asked where she would rather live, Jean said: "With Mommy and Daddy, but they don't seem to want me." The worker said a problem like that must be very hard for a little girl to think about. Jean tearfully and vigorously nodded. The worker then asked if Jean was afraid she had come to take her away. Again the child nodded, sobbing uncontrollably. The worker assured Jean that she was there to help Mommy and Daddy make things better for her and not to take her away.

Mr. and Mrs. K sat silently watching. The worker turned to them and asked whether the incident had meant anything to them. Mr. K replied, "It meant a lot. We have been so concerned with our own affairs we haven't thought what this

was doing to the children." Mr. K made the decision that he was going to stay with Mrs. K. When she asked him for how long he replied, "Forever."[2]

The problems of these immature parents were not solved with this decision. Improvement in their care of the children came slowly, with some reversal to former habits of uncleanliness and carelessness. But they did stay together and family relationships did improve.

The circumstances that prevent parents from being able to ask for help also make it difficult for some of them to face the fact that they have been neglecting or abusing their children. Yet, until the parents are able to face this fact, their energies are not freed for them to do something about the problem. A great amount of understanding, respect, acceptance, and skill is required to help parents who are caught in a struggle of denial and projecting blame on others. Many child welfare workers are acquiring competence in this.

The C family was referred to the child welfare agency by a hospital which treated the 6-year-old boy, Wade, for a broken arm suffered in a beating by his mother. Mr. C began the first interview with the worker by saying: "I want to say directly at the beginning that I approve of all my wife has done." He said the neighbors were prying into his business and they were "neurotic about the whole affair." Mrs. C agreed with him.

Mr. C then tried to deflect the conversation from the beating of the child by talking about the neighbors' interference in the past. The worker listened attentively but brought the subject back to the beating by saying that he could see they had had some trouble with their neighbors but the report of serious abuse of the children was the main concern now. Both parents said they whipped their children because they believed in firm discipline and they challenged the worker's right to question this. Mr. C again attempted to avoid the subject of Wade's beating by describing at length how strict his parents had been with him. Mrs. C said the children had "evil in them" which had to be controlled.

The worker said he could understand how Mr. and Mrs. C felt about his being there. He granted that the parents had the right to discipline their children, but pointed out that when a child is injured "the community wants to find out what the problems are and try to help the family. That's why I am here."

Mr. C maintained that there was not any problem. He began talking about one of the other children's difficulties in school, and with Mrs. C went into a long tirade about "young teachers" not being firm enough with youngsters.

Again the worker brought the conversation back to the Cs' own disciplinary practices by saying that children had to be dealt with firmly, but the injury of a child was a serious matter. He added: "I can understand that one may be so upset he has trouble controlling himself." Mrs. C hesitatingly said, "I was so upset and too angry" and broke into tears. The worker replied that if together they could try to understand why Mrs. C gets so upset, perhaps the behavior would not continue. Mr. C, who had been silent for a while, said he realized it was serious and that he did not approve of Mrs. C beating the children but did not know what to do. He had told her that this was bad for the youngsters but she continued. Mrs. C remarked that looking back on Wade's beating was a terrible experience. She did not realize she had injured him until his arm became swollen. She supposed it was her anger and her temper that did it. She would like to talk to someone and she does need help.[3]

In addition to reaching out to parents and initiating help, the agency must stay with the problem until more adequate care of the child is reasonably assured. At times this must be done in the face of the parents' objections.

Neighbors complained that a young mother was seriously neglecting her 4-month-old daughter, the first and only child. When the child welfare worker visited the home, she found the baby looking very pale and listless and apparently not in good physical condition. She persuaded the mother to take the baby to a clinic, where the child was found to be seriously malnourished and to have a severe diaper rash. On her next visit to the home, the worker found that the mother had apparently done nothing to carry out the doctor's instructions. As the worker talked to the mother about her lack of care and the seriousness of the baby's condition, the mother ordered her out of the house. The worker agreed to go but explained that she would have to continue her responsibility for seeing that the baby had more adequate care even to the point of filing a petition at court, if necessary.

The worker called in a public health nurse who helped the mother follow the doctor's instructions. The mother told the nurse how sorry she was about the way she had treated the child welfare worker and asked the nurse to tell her to return. The worker went back promptly and from then on was able to help the young mother and her husband grow in their ability to care for their child and to get pleasure from it. The child blossomed in her parents' care.[4]

### *Mutual Decisions*

Workers providing casework services to children in situations of neglect and abuse are always faced with the crucial decision—can the child be helped in his own home or is foster care required? To answer this question, the worker must have knowledge, skill in its use, sensitivity, and creativity in the diagnostic process. In addition he must understand parents and the meaning parenthood has for the individual.

The transition from being merely marriage partners to being capable parents is a developmental process that most parents achieve without too much difficulty. But this is not true for all parents. Sometimes because of circumstances in their past or present, their capacity for parenthood is blocked and cannot develop. With removal of pressures, fears, anxieties, or other impediments their capacity for parenthood may grow. In some instances however, because of their own previous deprivations, parents may lack the capacity to develop *at this time* the emotional maturity required for successful parenthood. The question is how to determine this.

I am constantly amazed and gratified at the growing skill of child welfare workers in evaluating the capacities of parents who have been neglecting their children. In many instances parents who at first seem hopeless in their parental relationships have developed with the child welfare worker's help into adequate parents, though often slowly and haltingly.

In others, the child welfare worker has helped parents face the fact that the best way to carry out their parental role is to release their child for adoption so that the child can have security and loving care in a family of his own. These decisions, of course, are not the worker's alone. They are decisions arrived at by worker and parents together.

Because social services provided in cases of child neglect and abuse have the primary purpose of protecting the child, child welfare workers sometimes give parents the impression that they are there to protect the child against the parents. It is natural and easy to identify with a helpless child who has been mistreated by adults and to feel that one must protect him against his dreadful parents. But such an attitude puts a barrier between worker and parents. Since help to the child must come through the parents by way of increased capacity to give him better care, the worker must begin at the point of the parents' interest in their child whatever that may be. For instance, the C's' interest in their children's "good behavior" was the point at which the worker began by supporting them in their conviction that children should be disciplined. The worker did not, however, condone their method. Such an approach helps to relieve the parents' fear of blame and condemnation by the worker.

Frequently, as with Mr. and Mrs. K, parents' own needs and problems are the stumbling blocks to their being more adequate parents. Before parents can even begin to think about the needs of their children, the worker must relate to the parents in terms of their own needs. Thus, a connection between the worker and the parents is made and movement can begin.

Any social agency providing casework services in relation to child neglect must make provision for temporary care of children in emergencies. Sometimes neglected or abused children are in immediate danger when called to the attention of child welfare agencies, and need more adequate care at once. Some child welfare agencies have carefully selected families to be available on a 24-hour basis to receive children into their homes for emergency foster care. Other child welfare agencies have established group-care or shelter-care facilities, which are under their administration.

A few agencies are experimenting in the use of homemaker services in emergencies. For example, when young children have been left unattended by parents, the agency instead of suddenly moving them to a strange environment sends a homemaker into the home to care for the children until the parents can be located. Homemakers are also being used in cases of neglect to help parents learn to give better care to the home and children, and, in some instances, to be a source of emotional support to immature parents.

### *Place of Other Agencies*

Providing social services to neglected children brings a child welfare agency into relationships with law enforcement officials and juvenile courts. Frequently instances of neglect, abuse, or exploitation are reported to law enforcement officials and sometimes investigated by them before the case is referred to a social agency. On the other hand, when a child welfare worker finds that an immediate danger requires removal of children from their homes without the knowledge or consent of their parents, she calls on the police, a sheriff, or other law enforcement officer to carry out this function. Thus child welfare workers and the police learn to understand, respect, and accept each other's functions. As understanding grows, the police are apt to refer to the agency more children and their parents in need of child welfare services for a variety of reasons.

The majority of all children coming to child welfare agencies for foster care have been committed by the courts. However, in many instances, the agency has had no part in determining the need for foster care. When there is good cooperative effort between the child welfare agency and the court the rights of the child and his parents are safeguarded and careful attention is given to the need of the child for foster care before he is committed to the agency for placement.

Sometimes a child's welfare makes it necessary for him to be cared for away from his own home. Only the court can interfere with the parent's right to the possession of his child. When a child is removed from a situation of immediate danger and placed in shelter care, an order from the court is required to detain him.

Since child welfare services for neglected children and their parents involve referrals to and from other agencies, they require the agency also to have a close working relationship with the public assistance agency, the schools, health agencies, mental health clinics, housing authorities, religious organizations, and other agencies. All of these relationships to be effective must be based on clear interpretation of agency function, goals, and methods of work, and well-thought-out plans for coordination of services.

As child welfare agencies provide more services to neglected children they insure for many of these children security in their own homes with their own parents. Nevertheless, foster care will continue to be needed for some children. But the purpose of placing a child in foster care will be clear, and the goal to be achieved through it will be thoughtfully planned as part of the decision to place him. Moreover, only those children who need foster placement to promote their well being will be placed in foster care.

### *Blocks to Service*

Today, however, many communities do not provide services to help families overcome problems leading to child neglect. Why have the majority of local public child welfare agencies not assumed responsibility for providing help to parents with such problems *before* the situation becomes so bad that court action is necessary? Part of the reason may have to do with tradition.

Historically child welfare agencies were begun out of a concern for children who had no families. Their emphasis was, therefore—and still is largely—on placing children in foster care or for adoption. Neither their staffs nor the community regarded them as responsible for strengthening the family life of children in order to keep children and their parents together.

However, today we know that we cannot regard children as if they were isolated entities who live in an emotional vacuum. We realize more clearly that a child, because of his immaturity and dependency, must always be viewed in relationship to adults, preferably his own parents—that social services for a child are services given to him in relation to his parents and the rest of his family, whether he lives in his own home or in a foster home or institution. The goal for each child is a secure family life.

Originally the protection of children from neglect, abuse, and exploitation was the province of "protective" or "humane" societies that in the beginning were not considered social agencies. Many of the early humane societies were set up to protect animals from cruelty and abuse and later took on the function of protecting children. In their early days these societies considered themselves law enforcing bodies rather than social agencies. They were empowered by law to remove children from their homes in situations of immediate danger without the knowledge or consent of parents and to arrest parents for neglecting or abusing their children. Over the years some of these societies have changed from law enforcement to social work agencies, employing competent social work staff and using social work methods to help neglected children and their parents. Some have given up their law enforcement functions while others have retained them.

These voluntary agencies, however, do not cover the country. Moreover, they are finding it increasingly difficult to meet all the need in the areas they were incorporated to serve. Some of them have had to limit the number of cases of child neglect they will accept.

At the present time many communities are recognizing that social services for neglected children and their parents should be a part of the public child welfare field. In community after community where studies have been made to determine the extent of child neglect and the need for services, the recommendation has been made that the public welfare agency provide such services.

In Cleveland for example, the welfare department has recently established a program of services in cases of child neglect as a result of a recommendation made by a citizens' committee. This committee had been appointed by the local welfare council to find a way to get services to neglected and abused children when it became apparent that no agency in the area was accepting complete responsibility for such children. Its recommendations were based on studies of the literature in the field, the State laws in regard to neglected children, and the practices of the local social casework agencies in relation to child neglect.[5]

One of the blocks to the development of social services for neglected children is the lack of legislation defining the public welfare agency's responsibility in this regard. Some States have no legislation empowering the public welfare agency to provide such services. In other States the enabling legislation is couched only in a general requirement that the State cooperate with the Federal Government in "extending and strengthening public welfare services for homeless, dependent and neglected children, and children in danger of becoming delinquent." Other States have laws giving overlapping responsibilities to public welfare agencies and juvenile courts. In these States the public welfare agencies tend to rely upon the court, which often receives the initial complaint, to act in all instances of neglect.

In some States the legislation is permissive—the welfare agency *may* provide service in neglect situations. But permissive legislation does not assure the

availability of service. Mandatory legislation specifically defining the public welfare agency's responsibility for children who are neglected or abused is the best way to make sure that all such children will receive social services.

Some factors in the development of social casework itself have hampered the expansion of programs of social services for children who are neglected and abused. As the profession of social work began to incorporate psychoanalytic concepts into its knowledge and practice, the notion that a person's ability to ask for help was an indication of his ability to benefit from help began to hold sway. As a result, if an individual needed help he had to ask for it. For many years most social agencies would not reach out to offer help to people who did not request it even though their need was evident.

The very nature of neglect problems prevents the people involved from asking for help. Being a *good parent* is one of the highest attainments and basic expectancies in our culture. To admit failure in one of the most fundamental aspects of human relationships—that of parent and child—is a terrible onslaught on the ego. Most neglecting parents cannot come to a social agency and say: "Help me—I am neglecting my child."

As our knowledge of human behavior and experience with people continues to grow we in social work are beginning to see that to ask for help is not in itself conclusive evidence that the applicant is ready to take help, and conversely, that the fact that a person has not asked for help does not mean that he does not want help or is unable to use it.

### *Confusion in Terms*

Another factor inhibiting the development of services to neglected children and their parents is the confusion about what these services are and what they can accomplish. Part of the confusion grows out of the fact that terms have been carried over from earlier days when law enforcement was the sole function of protective societies. In social work literature and elsewhere, the terms "authoritative agency" or an agency "with more authority" are often used in referring to an agency providing services to neglected children. This frightens administrators as well as child welfare workers. Some agency administrators have thought they must have some special kind of authority to reach out to people who have not requested help even though legislation has given them responsibility in neglect situations.

The truth is, an agency providing casework services to neglected children has no more authority than a social agency providing casework services in relation to other social problems. The agency does have a responsibility to respond to information about child neglect by reaching out to the family unasked in order to ascertain the validity of the facts of the complaint, evaluate the total situation, and determine a plan of action.

The agency initiates the contact, offers the parents help, but it cannot force them to take help. However, motivating parents to *want* help is part of the casework process. Child welfare workers cannot go into the home if the parents do not want them nor stay in if they are asked to leave. Their authority, as in all casework, lies in their knowledge and professional skill. When plans need to be made for taking children away from their parents, the court is the constituted authority to interfere in the relation between parents and child.

Other words carried over from the era of law enforcement confuse and confound us, such as complaint, complainant, investigation, and the like. These are not social work terms; they are legal terms.

The term "protective services" is confusing in tending to set these services apart from other casework services for children. Adoption and foster placement describe types of care. But what does "protective services" describe? All services for children are in a sense protective. To use such a broad term in so narrow a sense compounds confusion. Staff of the Children's Bureau have discontinued the use of the term "protective services." Instead we refer to services for children who are neglected, abused, or exploited.

There are some identifiable specifics in providing social services in relation to child neglect. These are: work with the referring person or agency; reaching out to parents who have not asked for help; determining whether or not neglect exists; knowing what is admissible evidence when seeking to file a petition at court; accepting responsibility to stay with the situation until the child's welfare is reasonably assured. The helping process, however, is the application of basic casework techniques to the problem of neglect and abuse.

### *Toward Progress*

Though the growth of social services for neglected children has been slow, nevertheless progress is being made. State and local public welfare agencies are increasingly developing these services. In some

agencies providing such services knowledge, understanding, and skill in evaluation and treatment are steadily improving.

Unfortunately, however, not all public welfare agencies giving services in child neglect are providing a top quality of services. The inadequacies usually stem from lack of administrative understanding and conviction about what good service is. Too often all the blame is put on the lack of trained personnel.

There is much that a public child welfare agency can do to develop a good service in spite of a shortage of trained, experienced child welfare workers. It can select nonprofessional staff members to work in child welfare who have interest, personality qualifications, and a college education, and provide them with educational leave for professional training. It can develop inservice training and provide competent supervisors to guide the workers and help them give services to parents and children. It can reduce caseloads to a size that will allow workers to give families the continuous help and support they need.

The fact that effective services are being provided to neglected children and their parents by some public child welfare agencies shows what can be achieved.

The best measure of what we can accomplish for all children lies in what we do for the abused and neglected child. Persons concerned with child welfare must move much more aggressively and at a much faster pace to see that social services are available for neglected children and for their parents. This requires community action as well as an increase and refinement of professional knowledge and skill on the part of child welfare workers. All of this must be achieved quickly because children cannot wait.

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[1] Perlman, Helen Harris: Social casework. University of Chicago Press, Chicago, 1957.

[2] New Hampshire State Department of Public Welfare. Case record (disguised for publication).

[3] Juvenile Protective Association, Chicago, Ill. Case record (disguised for publication).

[4] Children's Aid and Society for the Prevention of Cruelty to Children, Buffalo, N.Y. Case record (disguised for publication).

[5] Ward, David M.: Citizens' responsibility in the development of protective services to children. Paper presented at the 1959 forum of the National Conference on Social Welfare.

# Guides and Reports

CHILD WELFARE LEAGUE OF AMERICA STANDARDS FOR HOMEMAKER SERVICE FOR CHILDREN. 1959. 45 pp. $1.25. CHILD WELFARE LEAGUE OF AMERICA STANDARDS FOR ADOPTION SERVICE. 1959. 78 pp. $1.50. Child Welfare League of America, 345 East 46th Street, New York 17.

The first two reports of a projected series of statements on standards of various aspects of child welfare, prepared by special committees representing Child Welfare League of America's member agencies, various national organizations, and related professional groups.

FIRST ANNUAL WORKSHOP FOR HOUSEPARENTS OF FLORIDA'S INSTITUTIONS FOR CHILDREN, sponsored by Florida Group Child Care Association and Florida Department of Public Welfare, June 29-July 3, 1959. Stetson University, De Land, Fla. 1959. 80 pp. Copies available on request from Florida Department of Public Welfare, P.O. Box 989, Jacksonville, Fla.

Presents abstracts of five formal addresses and the outcome of discussion groups in anticipating and preventing problems among children; handling behavior problems; and the roles of the executive and houseparents.

BASIC APPROACHES TO MENTAL HEALTH IN THE SCHOOLS; a reprint series from the Personnel and Guidance Journal. American Personnel and Guidance Association, 1605 New Hampshire Avenue NW., Washington 9, D.C. 1959. 64 pp. $1. Ten percent discount on quantities of 10 or more.

Descriptions of six programs, carried on in various ways, to lead teachers and other school personnel to understand and help children.

THE NATURE OF THE HELPING PROCESS. National Association of Social Workers, Chicago Chapter, 123 West Madison Street, Chicago 2. 1959. 31 pp. $1.50.

Proceedings of an institute sponsored by the group work section of the Chicago Chapter of the National Association of Social Workers, with the subject approached from the standpoint of a psychoanalyst, an educator, a caseworker, and a groupworker.

THE UNMARRIED MOTHER. Ruth L. Butcher and Marion O. Robinson. Public Affairs Committee, 22 East 38th Street, New York 16. Public Affairs Pamphlet No. 282. 1959. 28 pp. 25 cents. Discounts on quantity orders.

Discusses the services needed by a girl or woman who becomes pregnant outside marriage, factors involved in her decision on keeping or relinquishing the baby, and problems of placement for adoption.

# FORMER FOSTER CHILDREN REFLECT ON THEIR CHILDHOOD

PAULA VAN DER WAALS, M.D.

*Formerly, honorary secretary, Tot Steun, Amsterdam, The Netherlands*

. . . Since I have been cared for by the agency, I have always looked forward to the day that I would come of age. And now, Madam, I really am 21 years of age. Everything is the same but at the same time everything has changed, because now I am free and I can do what I want. I now put a period to my past but all the same I hope to hear some time from you and from the agency. Greetings to you and to the whole agency from John.

THIS LETTER was written to Tot Steun, a child caring agency in Holland, by a young man who had spent his childhood with a foster family under the agency's supervision. It is similar to many others the agency has received from young people who have reached their majority and so have been released from its care.

What happened to you later, John? Was freedom as wonderful as you expected? Was everything really different after you came of age? Did you stay with or near your foster parents after all? Or did you try to contact your own parents? Did you go home and did you feel happy there? Do you still think that you can put a period to your past? Do you feel less curbed now by a social inferiority complex than when you were an "agency child"?

Each letter provoked such questions. As a result Tot Steun determined to find out what the experience of foster care had meant to its former wards at the time they were in care and how they looked back on the experience now that they were adults. Accordingly a few years ago (1952–54) it made a followup study of 200 former foster children born between 1903 and 1920 who had in the past been under its care for a considerable length of time.

The results of this inquiry have been published in Holland in a book entitled "Former Foster Children Give an Answer."[1] Although the work has not been published in English, its findings would certainly be of interest in the United States where considerable rethinking in regard to the uses and effects of foster care has been taking place.[2]

The parents of all of the children in the study had lost their parental rights because of neglect or abuse and the guardianship had been transferred to the agency by court order. At the time of the transfer the majority of the children had been between the ages of 3 and 14. Only a very few were under 2. Therefore most of them when interviewed had a more or less vivid recollection of life in their parental homes. In many instances this had been marked by a parent's alcoholism, prostitution, criminality, or mental defect, and by material deprivation and weak or severed ties between the parents.

The respondents of both sexes were chosen at random through an alphabetical system which included all the siblings of each child selected. For a number of reasons—immigration, death, residence in a mental institution, refusal to grant an interview, disappearance—40 of the 200 children could not be interviewed. Therefore the investigation actually included 160 former foster children.

The agency had only a little written information available about the children. This consisted mainly of financial arrangements for their care or brief records about transfers from one foster family to another or extreme behavior problems. Since the agency did not have well trained social workers at its disposal until the late thirties, no expert reports about the children's degree of adjustment in a foster

family, reasons for their removal, or other pertinent information existed.

At the time these children were under care, the agency worked with some 500 or 600 foster families and operated four institutions. All its foster placement was carried out by volunteers, board members, and interested members of the community, with much devotion and sometimes with a natural skill but without actual training for the task or knowledge about the needs of children who are separated from their parents or the problems and motives of foster parents.

Founded in 1886, Tot Steun was one of the first agencies in Holland to realize that for the majority of foster children life in a boarding family is preferable to life in an institution. It has always regarded placement in one of its institutions as a transition to placement in a foster family whether for the first time or after former foster family placement had failed. Since adoption did not exist in Holland at that time, the foster home placements were intended to be for a long period of time, frequently until the young person came of age, married, or went into military service.

### *The Interviews*

The follow-up inquiry was carried on by a social caseworker who was especially trained for work with foster families and the children placed with them. She visited personally all the respondents. She based her interviews on a rather elaborate questionnaire but did not produce this directly during her visits. She especially emphasized that she did not come to inspect or to criticize but, on the contrary, to enlist the respondents' help, as the agency hoped to be able through this research to improve its working methods. She listened to everything each respondent had to say and accepted his present situation without criticism or any show of doubt or surprise.

Most interviews took from 2 to 3 hours. Usually an initial resistance toward the unknown visitor had to be overcome as most respondents seemed to feel distrustful of a resumed contact with the agency. Some, obviously afraid that the caseworker had come to deprive them of their own children, spent considerable time in pointing out that they were really good parents and in describing the solidarity of their family group. Others assumed that the agency's representative had come to bill them for their former care and asked to be excused because of the high cost of living and their lack of money. Others expressed the fear that contact with the caseworker might result in difficulties in their work or with their marriage partner or with their friends, as they had not told anyone about having been a foster child. Sometimes the respondents showed considerable hostility, declaring that they had never asked to be cared for by an agency.

After being reassured on all these points, most of the respondents talked freely and at length about their experiences in foster care, their view of the care they had received, and their present circumstances. On the whole they seemed to appreciate the agency's renewed interest in them and the fact that their help was being enlisted. The incidents associated with violent emotions seemed to remain especially fresh in their memories.

### *Findings*

Among the many factors which seemed to be related to the success or the failure of the foster home placement were the ages of the child and of the foster parents. The child who was under 6 when placed had the advantage of having lived only a comparatively short period in the undesirable environment of his parental home. Moreover, the foster parents tended to look on a child placed with them early as more like their own than a child who was older when placed. Yet more than half of the respondents who were placed under 6 years of age had severed every contact with the foster family after coming of age; 74 percent of those over 6 when placed had severed such contact.

Although most of the respondents had been placed in complete families, 11 had been placed with widows, some of them very old. These respondents said that even as children they had realized that they were the main source of income for their foster mother. They had not got along well in the placement and none of them had kept in touch with their former foster mothers in later life.

More than half of all the respondents expressed strong negative feelings toward their former foster parents. They had many complaints, often very serious ones. To the question of why they had never succeeded in making a change in their miserable circumstances, they answered: "We were scared to death," or "So our lot was cast," or "What would have happened when we complained? No one would have believed us."

All complaints were connected with the feeling of being deprived materially as well as emotionally. "They never understood." "They did not treat us right." "They were much too strict." Such com-

plaints seemed to be results of attacks on the personality, of not being appreciated in the way they had wished to be.

Many of these complaints were obviously soundly based. Still in considering them it must be remembered that a foster child is apt to be even more sensitive than others to the attitudes of people toward him. Feelings of not being loved and appreciated induce a lack of self-confidence and a feeling of impotence which may be projected as blame and resentment, and may permanently distort the child's view of life.

On the other hand, about 25 percent of the respondents maintained positive feelings toward their foster parents, and after their coming of age kept in close contact with them. Among these were 10 mentally retarded persons who were still living with their foster parents or with the foster parents' married children.

The respondents who as children had felt perfectly at home with their foster parents made such remarks as: "These people loved us." "We felt that we belonged in the family group." "We never felt insecure, nor did we ever wish to return to our own parents."

In these happier foster homes the relationship between foster parents, own children, and foster children had been characterized by a tendency toward mutual understanding and mutual forgiveness. In case of a conflict a solution had been sought which would be acceptable for all parties involved. In later life the former foster children of these families sometimes named their children after their foster parents. Others took one or both of their foster parents into their own home or settled with their wives and children in the foster parents' home.

In the interviews the respondents with such fond recollections of their foster parents usually said that they did not recall what their own relationship was toward the agency's representative who came regularly to see their foster parents, but that they did remember that the visitor had been very welcome and held in high esteem by their foster parents. Incidentally, it might be well for the agency to find out more about the children and foster parents who got along so well. This might help to achieve a better insight into the placements which did not succeed.

About 25 percent of the respondents expressed mixed feelings toward their former foster homes. They had no serious complaints but said they never felt completely accepted in the foster family.

One woman told of how she went back to her own mother the day after she came of age without informing her foster mother or her employer. Her only contact with her own mother during the years that she had been away from home had been the annual receipt of a birthday card. The foster parents had been convinced that the mother did not mean anything to her as she had seldom mentioned her. Yet this woman described in detail the appearance of her mother, the house, and the street on the day she returned home, and said that it seemed that she never had been away. But she had forgotten the name of the foster mother and even the name of the village where she had lived for 8 years.

"They were good people," she said of her foster parents, "but I did not belong there." This is her only explanation of why she felt so completely indifferent toward the foster mother and why she had almost no recollections of this period in her life.

Many other respondents spoke of the strong emotional ties which had remained between themselves and their own parents. Twenty-five percent of them had always been able to believe in the real devotion of their mothers. Their mothers had kept in regular contact with them by writing or sending little gifts, thus reinforcing their feelings of self-confidence and self-respect. This feeling of being loved by their own mothers evidently helped in their relationship with the foster parents, for these respondents also tended to speak kindly of their foster parents.

However, a greater portion of respondents—75 percent—declared that they had kept no ties whatsoever with their own parents, who had severed every contact with them. Some of them said they had not suffered from this indifference. Others, however, expressed strong feelings of hostility toward their parents and spoke bitterly of how the parents had wronged them.

### *From Home to Home*

The agency has always tried to cut down the number of shifts of children from one placement to another as they are an unhappy experience for the foster family and can be disastrous for the child. The study indicated that a prolonged stay in an average foster home was preferable to many removals in search for the ideal foster home for the child.

Nevertheless, only 29 of the 160 respondents had stayed in the same foster family until they were discharged from the agency's care. All the others had been moved, either from one foster home to another, or alternately from foster home to institution to foster home. Some of them had been moved to

new placements three, four, or even more times.

What has been the reason for all these removals? Either the foster child did not fit in at all with the foster family or the family proved to be completely incapable of giving care to a deprived child who felt fundamentally unhappy and insecure. Many of the children had been so emotionally disturbed that they could not adapt to any foster family. Apparently many of them had used the foster mother as an object on which to transfer their negative and ambivalent feelings toward their own mothers. In this way they brought their own disturbed family relationships into the foster home.

Whether or not a child would accept or would reject the new environment seemed to depend as much on what his own family had to offer him in love and security as on his ability to switch from old relationships to new ones. Many respondents said they had learned for the first time in their foster family what social adaptation means.

A number of respondents who had been removed from foster homes several times complained that they had not been informed about their pending removal nor advised of what the reason for the removal was. They could only guess that either they had given too much trouble or the agency did not wish to pay an increase in board requested by the foster parents. Sometimes the foster parents took it out on the foster child when the removal was not accomplished as quickly as they desired.

Several respondents, who had been removed from one home after another, maintained that they had not suffered from this as they did not feel at home in the families from which they were being removed. They implied that they could adapt to any situation, but further discussion indicated that their reckless attitude was a kind of defense mechanism. They had backed out of every social contact which was not unavoidable.

### *View of Agency*

What had the respondents thought about the agency or the agency's representative who made the placement? Many evidently had felt uncomfortable because the agency's assistance had been a constant reminder of the fact that their own parents were unable or unwilling to provide for them.

The relationship between the foster parents and the agency had a lot to do with this. Many foster parents had presented the agency's representative to the child as a kind of bogeyman who punished every transgression and prohibited everything he liked. On the other hand, other foster parents had tried to push the agency completely into the background. They had wanted the child to think that they paid all the costs of care and when a visitor came from the agency they pretended that he was just an acquaintance. Such barriers had to be broken through by the agency's representative if he were to establish a satisfactory relationship with the child.

Many respondents felt indifferent toward the agency's representative, who apparently had shown little interest in and sympathy for them. When the representative visited the foster parents, they felt bullied or as though they were "on show." Rarely did the visitor talk personally with the foster child. Everything was arranged with the foster parents and when there were conflicts between foster parents and child, the foster parents were believed. The child was seldom given an opportunity to express his opinion.

In some cases, however, the agency's representative was very important to the child, listening to his problems and giving him comfort and devotion. In some instances the relationship carried over into the foster child's adulthood. There were some respondents in their 30's and 40's who said they never made an important decision without talking it over with the person whom they knew in their childhood as the representative from Tot Steun.

### *The Foster Families*

When the respondents were children most of Tot Steun's foster families lived in small rural communities, although most of the children in the agency's care came from cities. At that time the policy of child placing agencies was based on the assumption that a rural environment would be healthy and that the geniality, patience, and forbearance of the rural population would have a good influence on the child. The distance between the child and his own parents was deliberately made as great as possible in order to prevent contact between them. It was expected that as a result any interest which might still exist on either side would flag, making it easier for the child to adapt to his new environment.

The disadvantages to the child of this kind of placement had not been foreseen. Many respondents complained that they never had been completely accepted in the rural community. They had looked, talked, and behaved differently from the people around them. Something seemed to be wrong with them. They were looked down on as pitiful children, poor wretches, a special group, "charity children."

When a child had been placed in a foster family of a higher social or economic level, conflicts almost always arose. Usually, however, the financial position of the foster parents had been rather weak. Most of the respondents were still convinced that financial compensation had been the main reason that the family had taken them in. Many foster parents could hardly write.

Generally, the foster families had not had enough money to develop recreational interests. People in the country worked hard, had many worries, and went to bed early. The foster children had had to work after school in the fields, in the stable, or in the house. The foster parents' own children had to do the same, but sometimes they could unload the most hateful chores on the foster children.

### *Now and the Future*

The situation of many of these former foster children at the time of the inquiry left much to be desired. Socially, many were rather well established. Only a few were unemployed or antisocial, or had lost the parental rights to their own children. However, many felt unsuccessful, dissatisfied, and distressed. Emotionally unadjusted, they felt that their life had not been worth living.

Undoubtedly the future happiness of many foster children is spoiled before they come into an agency's care. However, Tot Steun now has a better program, carried out by a team of well trained social workers, with which it hopes to bring better opportunities to the children in its care for eventual adjustment. The members of the board, though carrying the final responsibility, have withdrawn from the technical work, the institution's practices have been improved, the foster families have been carefully selected, and they are receiving constant support from the agency's workers.

The process of foster home finding has been considerably refined. The question of why the prospective foster parents want to open their homes for one or more children is discussed with them at length. Many applicants for foster children are rejected because their application is based primarily on their own interests rather than on what they might do for a child. The applicant couple's past is also considered in respect to its probable influence on their relationship with a foster child. The social and intellectual level of a foster child and an applicant foster family are compared, as are the age differentials—which policy says should be neither too great nor too small. Finally, an attempt is made to discern whether the prospective foster parents are willing and able to cooperate with the agency and, still more important, with the child's own parents.

In the past the agency had not sufficiently recognized the everlasting importance to foster children of their own parents. Every foster child, even the one who has been taken from his parents at a very young age, at some time asks about his own parents, and later wants to see them. Children taken from their own homes at an older age almost always feel the need to keep in touch with their parents, the study has shown.

Tot Steun now operates on the theory that foster parents must be aware of this and must be willing to accept this contact, and sometimes even to stimulate it. Therefore, with a few necessary exceptions, it no longer places children as far away as possible from their original residence. It tries to find each child a home in or near the town in which one or both of his parents live, so that there are possibilities for the child to see his parents and relatives. This policy does not make the work easier. On the contrary, it is considerably more complicated for the agency as well as for the foster families, and sometimes for the children, to whom parental contacts may bring emotional distress. However, from a mental health point of view, the agency considers it essential.

Another inquiry is planned to take place 30 years after the first, so that the agency will be able to find out whether the results of its revised policies have actually meant improved work for children.

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[1] Alten, Ida: Oud pupillen antwoorden. Uitgeverij Ploegsma, Amsterdam, 1955.

[2] Maas, Henry L.: Children in need of parents. Columbia University Press, New York, 1959.

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Some day, maybe, there will exist a well-informed, well-considered, and yet fervent public conviction that the most deadly of all possible sins is the mutilation of a child's spirit. . . .

*Erik H. Erikson in* Young Man Luther, *W. W. Norton & Co., 1958*

# HERE AND THERE

## *Prevention and Management of Handicapping Conditions*

Approximately 90 professional people concerned with the administration of maternal and child health and crippled children's services, from 12 Midwestern States included in two regions of the Department of Health, Education, and Welfare, met in Ann Arbor, Mich., for 5 days in November in an institute on prevention and management of handicapping conditions in infancy and childhood. This was the second joint institute arranged by the departments of maternal and child health of the Schools of Public Health of the Universities of Minnesota and Michigan, in cooperation with the State maternal and child health and crippled children's agencies of their respective States. Participants in the institute included physicians, nurses, social workers, and nutritionists.

Figures were presented to show anticipated increases in the population under 21, up to 91 million in 1970. Data from the National Health Survey, correlated with this anticipated increase in children, were presented along with estimates concerning the number of handicapped children by then, thus pointing up the need for increases in preventive and therapeutic services.

Prevention of handicapping conditions due to prenatal and perinatal causes was emphasized, including steps which might be taken in the preconceptional, antepartal, intrapartal, and postnatal periods. The desirable approach to handicapping conditions, it was maintained, is prevention through the application of current knowledge.

The conferees discussed the consequences of some approaches currently being used in the management of children with handicapping conditions, including the results of present patterns of convalescent care; emphasis on pathology and deficits of children, rather than on their assets and abilities; lack of full consideration of the total needs of the child and his family; fragmentation of services and care of handicapped children; care in a residential setting. Measures suggested for preventing the negative consequences of present approaches were: the provision of more systematic followup of children seen in the clinics; the study of children rejected for care; the use of technical advisory committees; and the efforts to achieve better understanding of the home life of the disabled child and his family.

The need for indices and studies to measure the quality of medical care of mothers and children was pointed out. It was maintained that these are of special importance if progress in reduction of perinatal mortality and of handicapping conditions due to perinatal causes is to continue.

Some new directions in maternal and child health and crippled children's programs were presented as in need of greater emphasis. These included: the strengthening of parent counseling; studies of the effects of radiation; the development of standards for outpatient care of handicapped children, since more and more children will receive care while living at home; studies to identify trends in the patterns of hospital care of children; studies of the causes of the recent rise in infant mortality; the broadening of crippled children's services to cover additional types of handicaps, including epilepsy, congenital amputations, cystic fibrosis, and others.

Full proceedings of the Institute will be published shortly and may be secured by writing to Dr. Donald Smith, University of Michigan School of Public Health, Ann Arbor, Mich.

—Helen M. Wallace, M.D.

## *White House Conference*

A resolution calling for the establishment of a National Committee for Children and Youth to follow through on the recommendations of the Golden Anniversary White House Conference on Children and Youth was adopted by the President's National Committee on the White House Conference at a meeting in Washington in mid-October. The Conference is to be held in Washington March 27 to April 2, 1960.

The recommended committee would be established jointly by the Council of National Organizations on Children and Youth, the National Council of State Committees for Children and Youth, and the Interdepartmental Committee on Children and Youth. It would consist of 20 persons—5 representatives from each of these organizations and 5 members at large to be selected by them, the latter to be nominated in the first instance by the executive committee of the President's National Committee. Its purpose would be to stimulate implementation of the Conference findings by appropriate agencies and bodies, to coordinate the activities of its constituent groups, to provide for a continuing exchange of information concerning children and youth, and to plan joint activities of the constituent organizations and others interested in children and youth. The committee would be expected to hold its first meeting before October 1, 1960, and in 1965 to submit a report to the Nation reviewing and evaluating its activities and those of its constituents.

The resolution asked that the Children's Bureau be requested to staff the committee, that any residue of money from the White House Conference to be turned over to the committee for its operations, and that it consider the development of additional sources of funds.

In other recommendations adopted on the basis of a plan presented by its committee on followup, the President's National Committee urged: (1) that individual delegates work within their localities and States for the continuance of local and State committees for children and youth; (2) that State committees prepare reports on the Conference for their Governors; (3) that the present White House Conference staff prepare the final report of the Conference before dissolving; (4) that appropriate Government and voluntary agencies include implementation of the Conference findings in their program budgets and that each State provide for a continuing statewide committee for children and youth; (5) that the three organizations represented in the proposed National Committee for Children and Youth be adequately staffed; (6) that the Interdepartmental Committee on Children and Youth provide staff services not only to the National Council of State Committees as at pres-

ent but also to the Council of National Organizations on Children and Youth.

At the same meeting the President's committee adopted the line "Help Young America Grow in Freedom" as the slogan to be used on exhibits and all materials prepared for radio, television, magazines, and newspapers.

So far the Golden Anniversary White House Conference on Children and Youth has received grants from foundations and other voluntary organizations totaling $473,000 in addition to $350,000 in Federal funds received through Congressional appropriations.

Invitations to the Conference from the President of the United States will be issued about January 10, 1960, to 7,000 persons, including 700 young people and 500 nationals of foreign countries. The invitations will go to representatives of national organizations, State and local groups, and Federal agencies, as well as to Cabinet members, Supreme Court Justices, Members of Congress, and State Governors. The invited will include persons from urban and rural areas, youth, and representatives of minority groups, business, labor organizations, and various social and economic groups.

## *For Health*

The spread of poliomyelitis immunization, the control of staphylococcal infection, the development of homemaker service, and the improvement of health-unit administration were among the many concerns expressed at the annual meeting of the Association of State and Territorial Health Officers with the Children's Bureau and the Public Health Service in Washington last October.

Among some 40 recommendations made to the two agencies by the Association were the following: that the Public Health Service and the Children's Bureau create a committee to study local health administrative and financial structure and to recommend the most efficient method of administration; that they continue their studies of the effectiveness and use of poliomyelitis vaccine; expand their efforts to develop recommendations on control of hospital-acquired staphylococcal infections; join with other agencies in an effort to standardize the method of reporting cancer cases; keep the States informed of developments concerning the role of official health agencies in providing homemaker service; reinforce their activities in behalf of migrant laborers; and encourage fluoridation of public water supplies for prevention of dental caries.

The Association also recommended that the Children's Bureau study the service provided in regional heart centers, with the objective of achieving more equitable provision of care for children in all States.

## *Public Assistance*

Steps to eliminate the restricting effects of State residence requirements for eligibility to public assistance were urged by the Governors' Conference at its 51st meeting in San Juan, Puerto Rico, late last summer.

Noting that "a substantial segment of our population" migrates constantly from one State to another, and that persons so moving lose their eligibility for public assistance in their States of origin but usually do not qualify in any other State, the conference adopted a resolution recommending: (1) that a uniform one-year ceiling be established governing State residence requirements for eligibility for public assistance under Federally aided programs; (2) that State legislatures ratify an interstate compact providing that persons moving from one signatory State to another shall not be denied some form of aid if they are in need, irrespective of existing residence requirements; (3) that individual Governors, in their messages to the legislature, support the findings and recommendations of the Governors' Conference Special Committee on Residence Requirements for Public Assistance.

In its report the committee, appointed as the result of a resolution passed in 1958, found that the statelessness of bona fide citizens of the United States "creates an acute social welfare problem of human hardship which must not be tolerated in a nation of plenty, priding itself upon its concern for human need."

## *Adoptions*

The possibilities of (1) joint recruitment projects for finding adoptive families and of (2) adoption resource exchanges were the two main areas of attention at a meeting on interagency cooperation in adoptions held late in September at Highland Park, Ill., under the sponsorship of the Child Welfare League of America. Representatives of about 100 agencies attended.

Under a joint recruitment project, the conferees noted, the community's need for adoptive homes is explained to selected groups; couples considering adopting a child are referred to appropriate agencies; those who are shy about approaching an agency are reassured; and general information about adoption is spread.

Conferees stressed that before a joint recruitment project is started the participating agencies must have experience in working together, accept the fact that differences between them will occur, and develop policies and practices related to the project.

The adoption resource exchange was described as an administrative device through which a number of agencies, either within one State or in several States, agree to pass on to one another information on availability of adoptive homes and of children for whom adoptive homes are not readily available. It was emphasized that taking part in such an exchange does not relieve a participating agency of its responsibility for finding homes; that, on the contrary, extra time and effort is required of each agency to fulfill the agreement.

It was pointed out that both joint recruitment projects and adoption resource exchanges, though time consuming and expensive, have been successful in making more adoptive homes available; and that the alternative, long-time foster care, is still more costly, not only in money but also in damage to children.

## *Child Welfare*

More than 100 parents planning divorce were helped to use social casework counseling services in the first 10 months of a project being carried on since 1958 by the Family Service Agency of San Bernardino, Calif., in cooperation with the San Bernardino Council of Community Services and the State Department of Social Welfare, with the use of Federal child welfare services funds.

The agency obtains from public records the names of parents for whom divorce petitions have been filed and requests their attorneys to provide their addresses. Of 63 attorneys from whom addresses were requested in the first year of the project, 43 cooperated fully and 10 in part; 16 were evasive or

did not want their clients to be considered as part of the project. The project has the approval of the San Bernardino County Bar Association.

Each father and mother whose address the agency receives is sent a letter and a brochure, explaining the nature of family service and offering answers to some questions that often arise in the minds of parents planning divorce.

Of 477 persons who received the letter and brochure during the first 10 months of the project, 89 replied—all but one requesting counseling. Others were referred to the agency by their attorneys.

The project's counseling is not directed primarily toward reconciliation; but toward a solution of all kinds of divorce-related problems of parent and child.

. . .

Plans for a national conference on day care, to be held late this year under the sponsorship of the Children's Bureau, Department of Health, Education, and Welfare and the Women's Bureau of the Department of Labor, are now underway. The conference was recommended by a special advisory committee on day care which is working with the two Bureaus.

Purpose of the conference is to call nationwide attention to the day care needs of children of working mothers and to stimulate communities to appropriate action. The committee is representative of women's groups, national and State social and health agencies, church groups, labor organizations, and industry.

## *Mental Retardation*

An institute on mental retardation held in Fergus Falls, Minn., November 7, brought together physicians and dentists from four rural counties (Becker, Clay, Otter Tail, and Wilkin) to compare notes and share their experiences in serving mentally retarded children. The institute was sponsored by the Four County Project for Retarded Children, the section on dental health of the Minnesota State Department of Health, the local chapters of the Academy of General Practice, and the medical societies of the four counties and their district dental societies. Its purpose was to scrutinize some of the problems encountered in the Four County Project, a 4-year study and service program sponsored by the Minnesota State Departments of Health and Public Welfare. (See CHILDREN, September-October 1958, page 197.)

It was reported at the meeting that 919 children had been referred to the project as being mentally retarded as of last July; that of these children 241 had received complete medical, psychological, and social evaluations; that 205 of the latter had been referred for dental evaluation, and 113 of them had been given dental examinations. It was also reported that a field survey of the dental problems of these 113 children, interviews with all the dentists in the counties, and interviews with 96 parents had revealed the need for more adequate dental facilities, especially in hospitals; for a greater understanding of mentally retarded children by the professional personnel in the counties; and for ways of helping dentists to solve patient-management problems and other practical difficulties in serving patients of this type.

. . .

Two motion pictures on mental retardation made by State agencies with the cooperation of the Children's Bureau have recently been released: "Beyond the Shadows," by the Colorado State Department of Public Health, and "The Public Health Nurse and the Retarded Child," by the Oklahoma State Department of Health.

"Beyond the Shadows" shows how in one community the coordinated efforts of a number of State and local agencies to provide health, welfare, and evaluation services for the retarded supplemented the community's special educational services. Produced by Western Cine Productions in color and with sound, the film runs 26 minutes. It may be purchased or borrowed from the Colorado State Department of Public Health, 1422 Grant Street, Denver 3.

"The Public Health Nurse and the Retarded Child," planned as a training film for public health nurses, shows some of the techniques used by public health nurses in helping parents train a retarded child in activities of daily life. The film which runs 22 minutes, has sound and color. Produced by the University of Oklahoma, it was awarded third place in a list of ten best films selected by the University Film Producers Association. It may be rented or purchased from the International Film Bureau, 57 East Jackson Place, Chicago 4.

## *Poliomyelitis*

A change in the epidemic pattern in poliomyelitis which began to be evident in 1956 clearly emerged in 1959, according to an epidemiological analysis made by the Communicable Disease Center, Public Health Service. The analysis, which was reported on at the annual meeting of the American Public Health Association last October, showed that since 1956 polio epidemics had three main features: (1) the outbreaks occurred chiefly in crowded, low-income areas; (2) the disease reverted at least partially to an affliction of children; and (3) the paralytic cases occurred largely among persons who were not vaccinated or did not receive a complete series of vaccinations with the Salk vaccine.

Prior to 1956 there seemed to be no socioeconomic or racial pattern to outbreaks of the disease, though attack rates were sometimes greater among higher income groups. Since 1956, however, as the disease has focused largely on crowded slums, Negroes have been attacked to a greater extent than ever before. In Kansas City in 1959 and in Detroit in 1958 the incidence rate for Negroes was more than 10 times as great as that for whites.

The largest proportion of the 1959 cases of paralytic polio (slightly over 44 percent) occurred in children under 5 years of age, according to the report; 21.4 percent were in children 5 to 9 years; almost 13 percent in young people 10 to 19; and 12 percent in persons 20 to 29. In Seattle more than half the cases occurred in adults, most of them unvaccinated fathers of young children.

About two-thirds of the paralytic patients had received no inoculation of polio vaccine; 14 percent had received a course of three inoculations; only 2.5 percent had received four or more. On the other hand, more than half (57.8 percent) of the persons who had a nonparalytic type of polio in 1959 had received at least one inoculation of vaccine; 28 percent had received three injections; and 10.5 percent, four or more.

An analysis of the 1958 incidence of paralytic polio in relation to estimates of expected cases among the unvaccinated and among the triply vaccinated

indicated an effectiveness of the Salk vaccine of over 90 percent in the age group 0–9, and more than 80 percent in the age groups 10–19 and 20–29.

### *Miscellaneous*

Arrests of young people under 18 increased at a greater rate in cities with populations under 25,000 than in larger cities from the year 1957 to 1958, according to figures recently released by the Federal Bureau of Investigation in its annually published *Uniform Crime Reports*. The increase in the smaller cities was 12.6 percent, in larger cities 7.1 percent.

During the period 1953–58 overall figures for arrests of persons under 18 increased on an average of 10 percent *each year*, as against a 1 percent average yearly increase for adults. (During the same period the population in the age group 10–17 increased on an average of about 5 percent each year.) The increase in arrests of persons under 18 between 1957 and 1958—8 percent—was less than the yearly average for the period.

. . .

In connection with the nontaxable status of "sick pay" received by women employees absent from work during pregnancy, labor, and incapacitation after delivery or miscarriage, the Internal Revenue Service recently ruled that "sickness" exists from the beginning of labor to the end of incapacitation. The Service ruled also that "sickness" may be held to exist when a medical doctor states in writing that because of substantial danger, the woman should remain at home during pregnancy. "Sick pay" is excludable from gross income under the Internal Revenue Service Code.

. . .

Last summer the Health and Welfare Association of Allegheny County (Pittsburgh) sponsored a project under which a number of college students worked as members of agency staff. They helped social workers in their daily tasks, visited other social agencies, and attended conferences, agency staff meetings, and four seminars conducted by the University of Pittsburgh Graduate School of Social Work. Purpose of the project was to give the young people an opportunity to find out whether or not they would like to become social workers. Twenty-three students from 18 colleges participated.

# BOOK NOTES

PREDICTION AND OUTCOME; a study in child development. Sibylle Escalona and Grace Moore Heider. Menninger Clinic Monograph Series No. 14. Basic Books, New York. 1959. 319 pp. $6.50.

This book presents an analysis of methods of forecasting children's behavior at babyhood and of testing the predictions at a later age.

As part of a larger research project, intensive studies were made of 31 infants 8 months of age or younger. For each baby statements were prepared concerning a number of personality factors, such as activity, motor development, social behavior, and speech. When the children were 3 to 6 years old, each was again studied intensively, and the new data were compared with the predictions.

The predictions and the outcomes in each case are reported for a number of babies in detail, and factors associated with success in prediction and with failure are discussed.

Dr. Escalona is professor of psychology in the department of psychiatry of the Albert Einstein School of Medicine. Dr. Heider is a member of the research department at the Menninger Foundation.

THE MAGIC YEARS; understanding and handling the problems of early childhood. Selma H. Fraiberg. Charles Scribner's Sons, New York. 1959. 305 pp. $3.95.

This guide for parents covers three age periods or stages of personality development the first 18 months of life, the 18 months after that, and the years from ages 3 to 6. The book discusses the typical behavior of children in relation to their psychological development at these stages and makes suggestions for meeting the day-to-day problems that arise in these periods, such as feeding, toilet training, coping with the child's fears and anxieties, sex education, the development of conscience.

The author, who is associate professor of social casework at the School of Social Work, Tulane University, notes the incompleteness of present knowledge about children and describes the psychologists' problem of the future as "to find out how a child who is to be reared in our culture today can achieve the necessary harmony between his drives and his conscience and between his ego and his society. . . ." In her preface she acknowledges drawing a great deal in her own thinking on the works of Anna Freud, Rene Spitz, and other psychoanalytic investigators.

THE DEMONSTRATION CLINIC for the Psychological Study and Treatment of Mother and Child in Medical Practice. David M. Levy. Introduction by Leona Baumgartner. Charles C Thomas, Springfield, Ill. 1959. 120 pp. $5.

A continuing project to demonstrate to physicians and nurses techniques for including the emotional life of the child as part of pediatric health supervision is described in this book, written by the psychiatrist who developed the project for the New York City Health Department. One of the chief steps in the study and treatment of this phase of child health, according to the author, is to bring out expressions of the mother's feelings and attitudes toward her child.

How such expressions are elicited is shown through transcriptions of recordings of eight health-examination sessions in the Kips Bay District Health Center, a teaching clinic operated by the department. At each session the psychiatrist, joining in the discussions between the examining physician and the mother, demonstrates ways of leading the mother to express her feelings and of trying to strengthen or change her attitudes. While the discussions are going on, physicians and nurses in an adjoining room listen, and look on through a one-way screen.

At the end of each transcript, the author has added notes clarifying and amplifying the points demonstrated. The book also includes a transcript of a typical child health conference held in one of the city's health centers before the new techniques were instituted.

# IN THE JOURNALS

## *Effects of Mothering*

A greater degree of social responsiveness in babies cared for in an institution by one person than in those cared for by several persons was not detectable a year later when the babies were living in families, according to a report of a study by two psychologists on the staff of the National Institute of Mental Health. ("The Later Effects of an Experimental Modification of Mothering," by Harriet L. Rheingold and Nancy Bayley, in *Child Development* for September 1959.)

The study included 2 groups of 8 babies in a maternity hospital who were about 6 months old when the study began. For a 3-month period half of them had been cared for by one person; the rest by a number of persons—students, supervisors, and volunteers. Tests given at the beginning and at the end of the experimental period showed that the babies having one caretaker had become more responsive socially than had the others. No difference was found in developmental progress. Tests, given again when the children were about 18 months old and in their own homes or in foster homes, showed the two groups equal in social responsiveness and in development.

The authors emphasize that all the babies in both groups were healthy and of normal intelligence and seemed to be adjusting well, even when they were still in the institution. Unlike babies reported on in some other studies of the effects of institutional life, they did not show apathy or make excessive bids for attention.

## *Hospitalized Babies*

If a baby must be hospitalized for a short period and there is any choice about the time, this should be before he is 7 months of age in order to minimize disturbance caused by separation from his mother, say two investigators reporting on a study in *Pediatrics* for October 1959. ("Psychologic Effects of Hospitalization in Infancy," by H. R. Schaffer and W. M. Callender of the department of child psychiatry, Royal Hospital for Sick Children, Glasgow, Scotland.)

The study involved observation of 76 infants in the hospital and soon after returning home. About half were 1 to 28 weeks of age, the rest 29 to 51 weeks. The hospitalization period ranged from 4 to 45 days; about four-fifths of the infants were in the hospital 21 days or less.

The babies under 7 months of age showed little or no disturbance in the hospital, the authors found, in spite of absence of their mothers, of being cared for by strangers, and of an abrupt change in food and method of feeding. They showed no fright when confronted with the observers and were responsive to them. The older babies, on the other hand, in general showed considerable distress—crying and fretting—and were unresponsive.

At home, after discharge from the hospital, the younger babies for a short time showed some signs of upset such as sleep disturbance. In the older babies various signs of upset occurred, especially overdependence on the mother, and these lasted longer than those exhibited by the younger babies.

Reminding readers that the study involved only brief periods of hospitalization, the authors assert that the findings do not challenge the general principle that separation of infants from their mothers should be avoided whenever possible.

## *Theories on Foster Care*

Child placement in our culture may have to be considered an alternative among child-rearing possibilities rather than as a regrettable substitute, says Otto Pollak in the November 1959 issue of *Child Welfare*. ("Cultural Factors in Child Welfare Work.")

Some current research, the author maintains, indicates that a series of changes in foster-care placement do not create as much anxiety in children as do contacts with inadequate and disturbed parents. He suggests a change in policies that force families into staying together against the mental-health needs of both parents and children.

Commenting on Dr. Pollak's article in the same issue, Rosa Wessel of the University of Pennsylvania School of Social Work, reaffirms social work's strong belief in "the desirability of a child's growing up in a home with his own parents" and points out that the profession accepts a responsibility in cases of parental inadequacy for determining whether foster home placement or work with the child's own parents is in the "best interests of the child."

## *Help in Child Rearing*

Observing that the central task of the family agency is "to strengthen the family and to help parents discharge responsibly and adequately the child-rearing functions," Anne C. Schwartz, director of casework service, Jewish Family Service Association, Cleveland, expresses in the November 1959 issue of *Social Casework* her belief that the greatest promise for the family service field is work with parents of preschool children. ("Some Developments in Family Casework in Behalf of Children.") Detailing the case story of an adopted child who was creative and alert in nursery school, but immature and unhappy, the author describes the family agency's treatment of child and mother. She notes that the agency's methods vary with different families and children, but are all based on the concepts that early mother-child relationship is of vital importance and that the young child's personality is relatively more open to influence than an older child's.

## *Genesis of "Problem Families"*

On the basis of a sociological study of 52 "problem families," Harriett C. Wilson in the October 1959 issue of *Case Conference* (London) questions the concept that "immaturity" is the cause of the trouble in families so labeled by social agencies. ("Problem Families and the Concept of Immaturity.")

A large proportion of the families in the study, the author reports, had to face external conditions with which even the most mature and resourceful person would probably be unable to cope.

Factors in these families' difficulty, she describes as physical disabilities, mental handicaps, and economic insecurity. A parental attitude frequently found in problem families which closely resembles emotional retardation, she suggests, "may be no more than a regressive response to economic and psychological strain."

# READERS' EXCHANGE

DALE AND BANKS: *Not far enough*

Teamwork between physical and social planning is a concept about which we talk a lot but do little. The reasons for this situation are many, not least of which has been the vague, general, unimaginative approach to this concept by the social welfare field itself, the lack of flexibility on the part of agencies in approaching the human problems growing out of relocation, the lack of an integrated, coordinated attack upon relocation problems, and the tendency to bring an agency, rather than a community, approach to the situation.

The excellent reports on the experiences in Boston and Washington were, therefore, most encouraging. [See "Families and Children in Urban Redevelopment: I. A View from a Settlement House", by Jane Dale, and "II. A Demonstration of Services," by James G. Banks, CHILDREN, November-December 1959.] Both communities are to be complimented not only for their vision and courage in undertaking these projects but also for the critical evaluation of their programs. Pittsburgh's health and social welfare experience in relocation, which is still in the process of analysis, underscores many of the observations and findings in the Boston and Washington projects.

Despite the encouraging progress reflected in these reports, I believe we must go much farther if the social planners are to gain the respect and confidence of the physical planners, to be welcomed by them as partners, and to offer the community a program which will make an even greater impact on the human problems of urban redevelopment.

I recently had the opportunity to observe the courage and creativeness with which the physical planners designed a redevelopment plan for one of Pittsburgh's communities. It made major shifts in street patterns and land use. It provided for a shopping mall to replace the former traditional shopping district. It provided for traffic arteries which would route 60 percent of the present traffic around the area. The plan presents many problems to the business and commercial interests, schools, churches, and residents of the area. But it also presents them with tremendous opportunities.

This type of planning is going on in many cities. But where are the health and social welfare plans to parallel the physical plans? We just haven't produced them. We help with the individual human problems growing out of relocation. We become involved in the citizen participation dimension of urban renewal. But we do not develop the neighborhood plans for human redevelopment.

Health and social welfare agencies know that physical development alone is not enough. Decent, safe, sanitary housing will not eliminate our slums. There must also be a plan for human redevelopment. The question is "Can we produce it?"

*Elmer J. Tropman*
*Executive Director, Health and Welfare Association of Allegheny County (Pittsburgh).*

ROSE: *Points of agreement*

As a professional person who works with parents, individually as well as in groups, I would like to reemphasize several important points in John A. Rose's article, "Child Development and the Part-Time Mother" [CHILDREN, November–December 1959], with which I agree wholeheartedly:

1. Mothers who need to perform in other areas are not less interested in their child's development than other mothers.

2. Programs of child care which are designed to share the problems of care with parents and to *increase the sense of parental capacity* are likely to be more beneficial to the child, the family, and the State, than those in which professionals give parents a feeling of inadequacy.

3. There is great need for more *social support* for the shared care of children and more balance between separation and closeness in the child rearing task.

Some States are developing strong programs of training and licensing for personnel of day-care centers. It will be interesting to see what this development produces in parental satisfactions and better child development practices across the country in the next 10 years.

*Mildred I. Morgan*
*Professor, Home and Family Life, Florida State University, Tallahassee.*

YANKAUER: *Mutual Growth*

Dr. Yankauer's article ("Intercultural Communication in Technical Consultation," by Alfred Yankauer, CHILDREN, September–October 1959) is particularly gratifying in that it discusses the philosophical aspects of intercultural technical assistance and emphasizes the mutual-change aspects of the consultative process. Too often people writing on this subject have had a giver-receiver attitude that has sharpened the technological difference among the cultures. They have not appeared to appreciate the underlying values from which these differences are derived.

In my experience as a technical consultant, I too found that the development of self-confidence in those with whom I worked was of primary importance. It was also my experience to find that with growing self-confidence came the awareness of the need for more technical knowledge and skills. This was a growing together; as those with whom I worked increased their self-confidence, knowledge, and skills, I did too. This in turn sharpened our perceptions of desirable change and increased our skill in the selection and application of methods.

*Caroline G. Russell*
*Project Director, Nursing in Maternity and Newborn Care, George Washington University School of Medicine, Washington, D.C.*

RONEY AND WILTSE: *Compounded problems*

We have had over two decades of experience with the ADC program. I am numbered among the many who have clung tenaciously to a belief that, in time, the program benefits would spread and be reflected in an improved national program. In 1959, however, Mr. Roney graphically points up the num-

ber of States in prosperous America in which the program fails to meet a child's minimum food needs. His descriptions of the distance between administrative policies and the original purpose of the ADC program present a bleak future for children. Mr. Wiltse's frank appraisal of additional obstacles to be overcome if the ADC program is to get off the ground gives further emphasis to our dilemma of being on dead center. ["New Approaches to Aid to Dependent Children: I. Through Administrative Policies," by Jay L. Roney, and "II. Through Levels of Service," by Kermit T. Wiltse, CHILDREN, September-October 1959.]

I have pondered over the recommendations for new legislation, cited by Mr. Roney, trying to find in them indications that through the channel of legislation we might receive a strong push in a new direction. Broadening the programs would be a major step toward removing some of the inconsistencies in current social legislation. On the other hand, I have difficulty visualizing a broadened program (either through an overall program of general assistance or the addition of a fifth category) in relation to the obstacles Mr. Roney and Mr. Wiltse describe.

Under a broadened program the problems of lack of money, negative public attitudes, heavy caseloads, and an insufficiency of experienced, trained personnel might be compounded. Reliable research shows that these problems now exist to a serious degree.

To interpret this reminder as opposition to the proposed legislation would be unjust to one who seeks help in understanding an apparent contradiction which ultimately may have serious ramifications for all persons in need of money and services.

The able, experienced minds that conceived the proposals for broadening national legislation, I am confident, assessed the future of needy people thoughtfully against the background of our 21 years of experience. They might be willing to share their speculations about the areas in which parents and children stand to gain or lose through broadened legislation. Articles with this focus would better prepare me for making some important decisions—for example, a decision as to which of the legislative proposals I could support with good conscience; and whether to continue to wish with Mr. Roney that gentle persuasion will change administrative policy, or to hope with Mr. Wiltse that despite overwhelming obstacles, providing three levels of service is worth a try.

*Anne Wilkens*
*School of Social Work, University of Texas, Austin.*

**BECK:** *Some questions*

Miss Beck's article prompts a stock-taking of the reported experiences offered in the growing literature from newly organized clinics for retarded children and their families. ["Counseling Parents of Retarded Children," by Helen L. Beck, CHILDREN, November–December 1959.]

These reports commonly suggest that: (1) Casework with parents is an integral and important necessity in serving the retarded child; (2) Such help should be given as soon after the diagnosis of the child's condition as possible; Giving it (3) requires skill, sensitivity, and training; It (4) involves a blend of emotional support with practical assistance in handling everyday problems; (5) Parents need not be completely "accepting" of the child's condition in order to derive benefit from work directed toward amelioration of their immediate problems; (6) It is neither feasible nor necessary to offer counseling to all parents who come to clinics; (7) Different parents require different forms of counseling assistance.

Miss Beck touched on another important point; that there are many common features between work with retarded children and work with children having other types of handicaps. Recognition of this may make problems of training and educating counseling personnel less perplexing and may indicate how health and welfare agencies may appropriately extend their services to retarded children and their parents.

The time now seems ripe for materials which go beyond descriptions of clinic programs and focus on areas of needed elaboration. Some questions for study in this and related fields are how to identify parents who are prone to breakdown or disorganization and how to identify parents who can benefit from the different modes of counseling.

Another problem which needs greater emphasis is the fact that the early identification and diagnosis of retarded children is for the most part handled by family physicians or pediatricians, many of whom may be ill equipped to offer the kind of counseling assistance necessary for many families. Since it does not appear likely that special clinics can handle all of these problems, the question of orienting and educating these key physician groups becomes crucial in any community program to meet the needs of retarded children and their families.

*Howard R. Kelman*
*Departments of Physical Medicine and Rehabilitation, and Preventive Medicine, New York Medical College, New York.*

**NOVICK:** *An earlier effort*

It was encouraging to read in the review of "Cost Analysis in Child Welfare Services," by Edward E. Schwartz and Martin Wolins, of the growing recognition for the use of work measurement and cost analysis services rendered by social agencies. ["Administrative Research in Social Agencies," by Mary B. Novick, CHILDREN, September–October 1959.] I should like, however, to point out that while the efforts of Schwartz and Wolins represent the first publication, there has been an earlier effort of this kind (unpublished material) in the field of child welfare services.

For my graduate dissertation at the Bryn Mawr College Graduate School of Social Work and Research, in 1954, I presented "A Cost Analysis of Services Rendered by the Delaware County Children's Aid Society." This pilot study represented an attempt to adapt the method of cost analysis to determine the total costs of the agency's program of services (both direct and indirect). It involved an analysis not only of the agency's expenditures, but also of the use of staff time.

The dissertation provides a detailed and graphic description of the method, its application, and the results achieved in a child placing agency. It was the hope that as the method was applied in other agencies in the children's field, a greater degree of refinement and precision would be attained.

This current report of the work done by Schwartz and Wolins indicates that this has been accomplished.

*Claire E. Wompierski*
*Chief Psychiatric Social Worker, Child Guidance Clinic of Delaware County, Media, Pa.*

## SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

**Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.**

THE CHILD WITH A MISSING ARM OR LEG. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Folder No. 49. 1959. 25 pp. 10 cents.

This pamphlet for parents of child amputees tells about improvements that have been made in artificial limbs for children; explains the functions of a professional team of doctor, prosthetist, physical and occupational therapist, psychologist, social worker, and public health nurse in fitting a prosthesis to a child and helping him to use it; discusses desirable parental attitudes toward the child with an artificial limb; and provides instructions on the care of the stump and the prosthesis.

RESEARCH RELATING TO CHILDREN, BULLETIN 10. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1959. 158 pp. $1.

This volume presents abstracts of studies in progress on growth and development; personality and adjustment; educational process; exceptional children; the family; social, economic, and cultural influences; health services; and social services. It does not include studies reported in previous bulletins.

SELF-TRAINING UNIT ON CHILD-LABOR LAWS FOR YOUTH PLACEMENT WORKERS. Department of Labor, Bureau of Labor Standards. Bulletin 202. 1959. 18 pp. 15 cents. Limited number of copies available without charge from the Bureau of Labor Standards.

Planned to help youth placement workers to become familiar with the Federal and State laws and local regulations affecting youth placement, this bulletin emphasizes the purposes of child labor restrictions and of continuation schools. It describes the child labor provisions of the Fair Labor Standards and the Walsh-Healy Public Contracts Act, and provides blanks for the worker to fill out to show his own State's and municipality's requirements concerning minimum age for employment, maximum hours for minors of different ages, and restricted occupations.

JUVENILE COURT STATISTICS 1957. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 52. 1959. 17 pp. Single copies free.

The figures given in this publication show the volume of children's cases disposed of by juvenile courts. They include juvenile delinquency cases reported by 500 courts in sample locations of the United States, and dependency and neglect cases reported by more than 1,300 courts.

JOB GUIDE FOR YOUNG WORKERS, 1958–59 edition. Department of Labor, Bureau of Employment Security, U.S. Employment Service, in cooperation with State employment security agencies. 66 pp. 40 cents.

Describes more than 100 occupations available to young people with no more than a high school education. Provides information on the duties and characteristics of each occupation, qualifications required, employment prospects, opportunities for advancement, and methods of entry.

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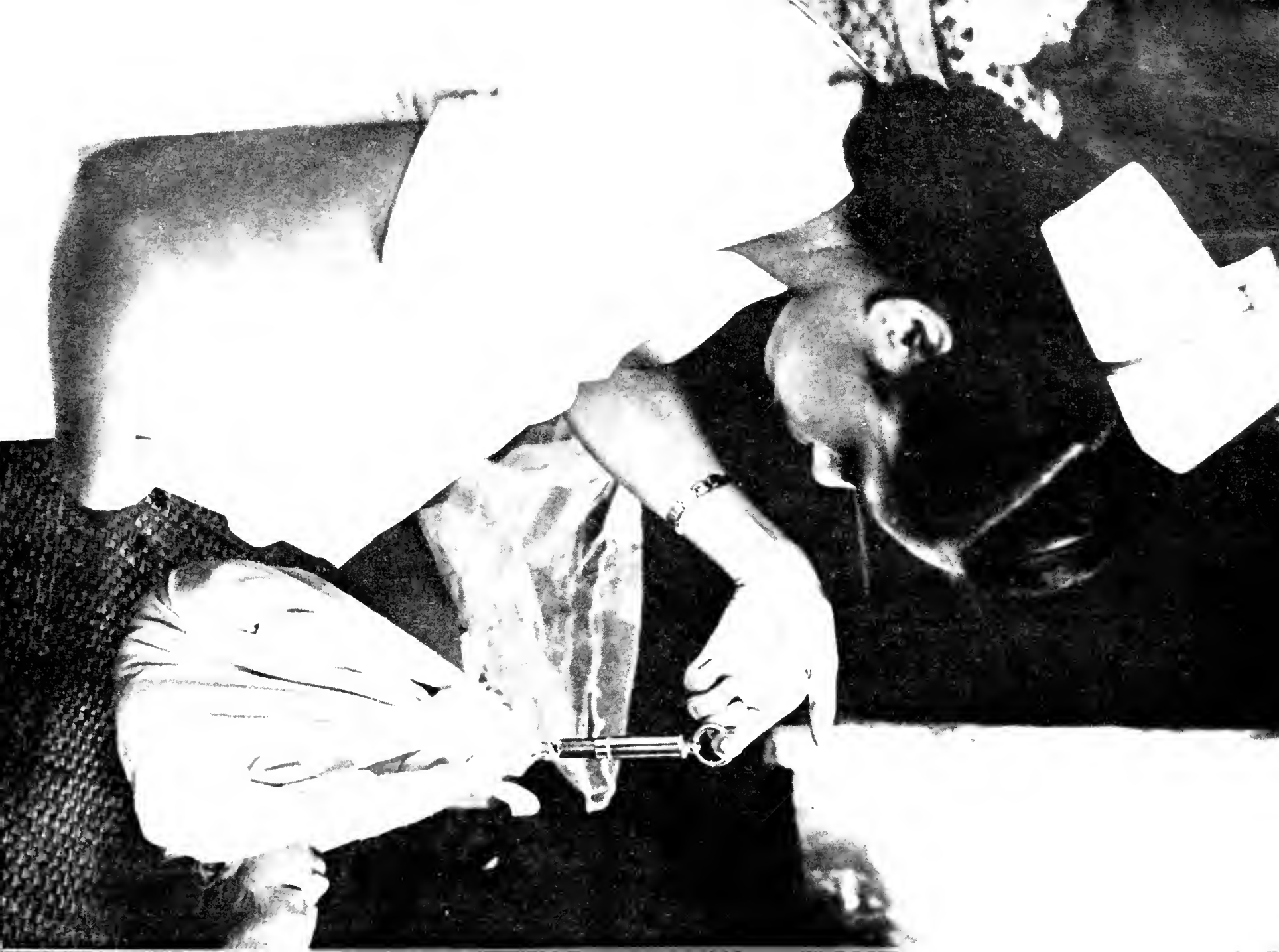
## Youth and the Life Cycle

## Reports to White House Conference

## Smoking Among Teenagers

## Recommendations on Child Welfare



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child ®

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"HE SHALL BE ENTITLED to grow and develop in health. . . ." So has declared the United Nations of this new infant of the Philippines and of all other children in the world, through a Declaration of the Rights of the Child, adopted unanimously by the General Assembly on November 20, 1959. (Full text on page 74.) Twenty-eight nations were involved over a period of 12 years in preparing the draft of the declaration which was transmitted to the Assembly last summer by the Economic and Social Council.

Beginning on July 1, Erik H. Erikson will become professor of human development and lecturer in psychiatry at Harvard University, teaching undergraduates as well as medical and other graduate students and continuing his clinical studies. He will continue to serve the Austen Riggs Center as consultant. A graduate of the Vienna Psychoanalytic Institute, he is now a professor at the University of Pittsburgh's School of Medicine.

Besides working with the Interdepartmental Committee on Children and Youth, Betty Barton, left, has been assistant to the Chief of the Children's Bureau since 1954. Previously she spent 7 years working with displaced persons and refugees in Germany and Austria—for UNRRA, the American Friends Service Committee, and the U.S. Department of State. Katharine Pringle, right, has worked for *Time, Life, and Fortune*, and has done free-lance writing.

A member of the board of the Council of National Organizations, Edward A. Richards has served on the editorial advisory committee for the volume which will summarize reports of national organizations to the 1960 White House Conference. Before taking his present position last August, he was for 13 years deputy director of the American Junior Red Cross. He has recently published his second book of poems, "Cathedral."

Since receiving his Ph. D. in psychology at Harvard University, Daniel Horn has done research in the psychological factors in aircraft accidents, the epidemiology of lung cancer, and public opinion as it relates to health education problems. He has been on the staff of the American Cancer Society for the past thirteen years.

A social work graduate of the Universities of Utah and Denver, John C. Kidneigh has been director of the University of Minnesota School of Social Work for more than a decade. He has held positions in child welfare, public welfare, and community organization as practitioner, administrator and teacher, and various professional offices.

Alex Rosen won the Annisfield-Wolf Award from *Saturday Review* in 1956, with John P. Dean, for their book, "Manual on Intergroup Relations." Mr. Rosen has served as assistant director of Cornell University's study of intergroup relations and as member of the faculty at New York University and at Yeshiva University.

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TEN YEARS AGO in his book, "Childhood and Society,"[1] Erik H. Erikson, psychoanalyst, teacher, and artist, presented a life cycle theory of personality development in which social drives play as important a part as biological urges in the child's struggle toward maturity. The theory, elaborated by Professor Erikson in a paper entitled "Growth and Crises of the Healthy Personality,"[2] became the core of the factfinding material presented to the Midcentury White House Conference on Children and Youth, a conference focused on the development of a healthy personality. In the ensuing decade Erikson's eight "stages of psychosocial development," each harboring a special crisis which must be fought through before the next stage can be reached, have become as familiar to students of child development as the dangers confronted by John Bunyan's Christian were to the persons who guided children a century ago. They have been emphasized not only in the training of psychiatrists, but also in the training of teachers, nurses, social workers, and parent educators and in parent discussion groups in places far and wide. A brief description of each stage and the special crisis it harbors is presented in the box on page 45.

With the Midcentury White House Conference fading into history the question now arises as to the pertinence of its core theory to the problems to which the participants of the approaching Golden Anniversary Conference on Children and Youth will be addressing themselves. In what directions has the originator of this conception of child development been thinking in the interim? What concerns him most today about the youth in "the world around the young" and "the young in the world," the twin subjects of the new Conference? How would he apply his life-cycle theory to the Conference's theme-stated emphasis on values?

With such questions in mind, the editor of CHILDREN recently spent a day with Professor Erikson. The following article is based on this interview.

# YOUTH AND THE LIFE CYCLE

an interview with ERIK H. ERIKSON

*Senior Staff Member, Austen Riggs Center, Stockbridge, Mass.*

**Question:** ***Are there any points about your concepts of psychosocial development which you would now like to stress in the light of what you have heard about how they have been interpreted during the past decade in the training of professional persons and through them of parents and future parents?***

Yes, I am grateful for the opportunity of making a few observations on the reception of these concepts. You emphasize their influence on teaching in various fields; let me pick out a few misunderstandings.

I should confess to you here how it all started. It was on a drive in the countryside with Mrs. Erikson that I became a bit expansive, telling her about a kind of ground plan in the human life cycle, which I seemed to discern in life histories. After a while she began to write, urging me just to go on; she had found my "plan" immediately convincing. Afterwards, a number of audiences of different professional backgrounds had that same sense of conviction—so much so that I (and others) became somewhat uneasy: after all, these psychosocial signposts are hardly *concepts* yet, even if the whole plan represents a valid *conception*, one which suggests a great deal of work.

What Mrs. Erikson and I subsequently offered to the White House Conference of 1950 was a kind of worksheet, which has, indeed, been used by others as well as myself in scientific investigation, and well integrated in a few textbooks.[3] But its "convincingness" has also led to oversimplifications. Let me tell you about a few.

There has been a tendency here and there to turn the eight stages into a sort of rosary of achievement, a device for counting the fruits of each stage—trust, autonomy, initiative, and so forth—as though each were achieved as a permanent trait. People of this bent are apt to leave out the negative counterparts of each stage, as if the healthy personality had per-

manently conquered these hazards. The fact is that the healthy personality must reconquer them continuously in the same way that the body's metabolism resists decay. All that we learn are certain fundamental means and mechanisms for retaining and regaining mastery. Life is a sequence not only of developmental but also of accidental crises. It is hardest to take when both types of crisis coincide.

In each crisis, under favorable conditions, the positive is likely to outbalance the negative, and each reintegration builds strength for the next crisis. But the negative is always with us to some degree in the form of a measure of infantile anxiety, fear of abandonment—a residue of immaturity carried throughout life, which is perhaps the price man has to pay for a childhood long enough to permit him to be the learning and the teaching animal, and thus to achieve his particular mastery of reality.

You may be interested to know that further clinical research has indicated that our dream life often depicts a recovery of mastery along the lines of these stages. Moreover, nurses have observed that any adult who undergoes serious surgery has to repeat the battle with these nemeses in the process of recovery. A person moves up and down the scale of maturity, but if his ego has gained a positive balance during his developmental crises the downward movements will be less devastating than if the balance, at one stage or another, was in the negative.

Of all the positive aspects mentioned, trust seems to have been the most convincing—so convincing, in fact, that some discussions never reach a consideration of the other stages. I don't mean to detract from the obvious importance of trust as the foundation of the development of a healthy personality. A basic sense of trust in living as such, developed in infancy through the reciprocal relationship of child and mother, is essential to winning the positive fruits of all the succeeding crises in the life cycle: maybe this is what Christmas, with its Madonna images, conveys to us. Yet, it is the nature of human life that each succeeding crisis takes place within a widened social radius where an ever-larger number of significant persons have a bearing on the outcome. There is in childhood, first, the maternal person, then the parental combination, then the basic family and other instructing adults. Youth demands "confirmation" from strangers who hold to a design of life; and later, the adult needs challenges from mates and partners, and even from his growing children and expanding works, in order to continue to grow himself. And all of these relationships must be imbedded in an "ethos," a cultural order, to guide the individual's course.

In our one-family culture (supported by pediatricians and psychiatrists who exclusively emphasize the mother-child relationship) we tend to lose sight of the fact that other people besides parents are important to youth. Too often we ask only where a given youth came from and what he once was, and not also where he was going, and who was ready to receive him and his intentions and his specific gifts. Thus we have movements to punish parents for the transgressions of their children, ignoring all the other persons and environmental factors that entered into the production of a young person's unacceptable behavior and failed to offer support to his positive search.

Another way in which the life cycle theory has been oversimplified is in the omission of stages which do not fit into the preconceived ideas of the person who is adopting or adapting the theory. Thus a large organization devoted to parenthood distributed a list of the stages but omitted *integrity vs. despair*—the problem of senescence. This is too easy a way to dispose of grandparents; it robs life of an inescapable final step; and, of course, it defeats this whole conception of an intrinsic order in the life cycle.

This kind of omission ignores the "cogwheeling" of infantile and adult stages—the fact that each further stage of growth in a given individual is not only dependent upon the relatively successful completion of his own previous stages, but also on the completion of the subsequent stages in those other individuals with whom he interacts and whom he accepts as models.

Finally, I should point to the fact that what my psychoanalytic colleagues warned me of most energetically has, on occasion, come to pass; even sincere workers have chosen to ignore my emphasis on the intrinsic relation of the psychosocial to the psychosexual stages which form the basis of much of Freud's work.

All of these misuses, however, may be to a large extent the fault of my choice of words. The use of simple, familiar words like "trust" and "mistrust" apparently leads people to assume that they know "by feel" what the theory is all about. Perhaps this semantic problem would have been avoided if I had used Latin terms, which call for definitions.

I may point out, however, that I originally suggested my terms as a basis for discussions—discussions led by people who have an idea of the

## The Eight Stages in the Life Cycle of Man

"Personality," Erikson has written, "can be said to develop according to steps predetermined in the human organism's readiness to be driven toward, to be aware of, and to interact with a widening social radius, beginning with a dim image of a mother and ending with an image of mankind. . . ." Following are the steps he has identified in man's psychosocial development, and the special crises they bring. In presenting them, he has emphasized that while the struggle between the negatives and positives in each crisis must be fought through successfully if the next developmental stage is to be reached, no victory is completely or forever won.

I. **Infancy: Trust *vs.* Mistrust.** The first "task" of the infant is to develop "the cornerstone of a healthy personality," a basic sense of trust—in himself and in his environment. This comes from a feeling of inner goodness derived from "the mutual regulation of his receptive capacities with the maternal techniques of provision"[2]—a quality of care that transmits a sense of trustworthiness and meaning. The danger, most acute in the second half of the first year, is that discontinuities in care may increase a natural sense of loss, as the child gradually recognizes his separateness from his mother, to a basic sense of mistrust that may last through life.

II. **Early Childhood: Autonomy *vs.* Shame and Doubt.** With muscular maturation the child experiments with holding on and letting go and begins to attach enormous value to his autonomous will. The danger here is the development of a deep sense of shame and doubt if he is deprived of the opportunity to learn to develop his will as he learns his "duty," and therefore learns to expect defeat in any battle of wills with those who are bigger and stronger.

III. **Play Age: Initiative *vs.* Guilt.** In this stage the child's imagination is greatly expanded because of his increased ability to move around freely and to communicate. It is an age of intrusive activity, avid curiosity, and consuming fantasies which lead to feelings of guilt and anxiety. It is also the stage of the establishment of conscience. If this tendency to feel guilty is "overburdened by all-too-eager adults" the child may develop a deep-seated conviction that he is essentially bad, with a resultant stifling of initiative or an conversion of his moralism to vindictiveness.

IV. **School Age: Industry *vs.* Inferiority.** The long period of sexual latency before puberty is the age when the child wants to learn how to do and make things with others. In learning to accept instruction and to win recognition by producing "things" he opens the way for the capacity of work enjoyment. The danger in this period is the development of a sense of inadequacy and inferiority in a child who does not receive recognition for his efforts.

V. **Adolescence: Identity *vs.* Identity Diffusion.** The physiological revolution that comes with puberty—rapid body growth and sexual maturity—forces the young person to question "all sameness and continuities relied on earlier" and to "refight many of the earlier battles." The developmental task is to integrate childhood identifications "with the basic biological drives, native endowment, and the opportunities offered in social roles." The danger is that identity diffusion, temporarily unavoidable in this period of physical and psychological upheaval, may result in a permanent inability to "take hold" or, because of youth's tendency to total commitment, in the fixation in the young person of a negative identity, a devoted attempt to become what parents, class, or community do not want him to be.

VI. **Young Adulthood: Intimacy *vs.* Isolation.** Only as a young person begins to feel more secure in his identity is he able to establish intimacy with himself (with his inner life) and with others, both in friendships and eventually in a love-based mutually satisfying sexual relationship with a member of the opposite sex. A person who cannot enter wholly into an intimate relationship because of the fear of losing his identity may develop a deep sense of isolation.

VII. **Adulthood: Generativity *vs.* Self-absorption.** Out of the intimacies of adulthood grows generativity—the mature person's interest in establishing and guiding the next generation. The lack of this results in self-absorption and frequently in a "pervading sense of stagnation and interpersonal impoverishment."

VIII. **Senescence: Integrity *vs.* Disgust.** The person who has achieved a satisfying intimacy with other human beings and who has adapted to the triumphs and disappointments of his generative activities as parent and coworker reaches the end of life with a certain ego integrity—an acceptance of his own responsibility for what his life is and was and of its place in the flow of history. Without this "accrued ego integration" there is despair, usually marked by a display of displeasure and disgust.

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interrelatedness of all aspects of human development. For the eight stages of psychosocial development are, in fact, inextricably entwined in and derived from the various stages of psychosexual development that were described by Freud, as well as from the child's stages of physical, motor, and cognitive development. Each type of development affects the other and is affected by it. Thus, I feel that discussants would do well to study each key word in its origins, in its usage in various periods and regions, and in other languages. Simple words that touch upon universal human values have their counterpart in every living language, and can become vehicles of understanding at international conferences.

Incidentally, I made up one new word because I thought it was needed. To me, "generativity" described the chief characteristic of the mature adult. It was turned into a comfortable, if inaccurate, homespun word before it ever left the Fact-Finding Committee of 1950. I had deliberately chosen "generativity" rather than "parenthood," or "creativity," because these narrowed the matter down to a biological and an artistic issue instead of describing the deep absorption in guiding the young or in helping to create a new world for the young, which is a mark of maturity in parents and nonparents, working people and "creative" people alike.

Enough of this fault-finding! But it *is* interesting to see what can happen to new ideas; and you *did* ask me.

Question: *During the past 10 years you have been treating and studying mentally ill young people at a public clinic in a low-income area in Pittsburgh and at a private, comparatively expensive, mental hospital in the Berksbires. Have you found any common denominator in the disturbances of these patients—from such opposite walks of life—that would seem to point to any special difficulty harassing the young people of our land today?*

Since 1950, I have concentrated on the life histories of sick young people in late adolescence and early adulthood primarily in order to study one of the crises magnified, as it were, with the clinical microscope. I think that our initial formulations of the identity crisis have been clinically validated and much refined.[4]

Many of these sick young people in their late teens and early twenties had failed during their adolescence to win out in the struggle against identity confusion. They were suffering so seriously from a feeling of being (or, indeed, wanting to be) "nobody" that they were withdrawing from reality, and in some cases even attempting to withdraw from life itself: in other words, they were regressing to a position where trust had to be reinstated. Their malaise proved to be related to the same sense of diffuseness which drives other young adults to incessant and sometimes delinquent activity—an effort to show the world, including themselves, that they are "somebody" even if deep down they do not believe it.

In the meantime, of course, the identity issue has been taken up by many writers and by some magazines, almost in the form of a slogan. We are prone to think that we have cornered an issue when we have found a name for it, and to have resolved it when we have found something to blame. So now we blame "the changing world."

Actually, there is no reason why youth should not participate with enthusiasm in radical change; young people are freer for change than we are. The bewildering thing for them must be that we now complain about change, having eagerly caused it ourselves with inventions and discoveries; that we seem to have played at change rather than to have planned it. If we had the courage of our inventions, if we would grow into the world we have helped to create, and would give youth co-responsibility in it, I think that all the potential power of the identity crisis would serve a better world than we can now envisage.

Let me say a word about identity, or rather about what it is not. The young person seeking an identity does not go around saying, even to himself, "Who am I?" as an editorial in a national magazine suggested last year's college graduates were doing on their way home. Nor does the person with a secure sense of identity usually stop to think or to brag about the fact that he has this priceless possession, and of what it consists. He simply feels and acts predominantly in tune with himself, his capacities, and his opportunities: and he has the inner means and finds the outer ways to recover from experiences which impair this feeling. He knows where he fits (or knowingly prefers not to fit) into present conditions and developments.

This sense of a coincidence between inner resources, traditional values, and opportunities of action is derived from a fusion of slowly grown, unconscious personality processes—and contemporary social forces. It has its earliest beginnings in the infant's first feelings of affirmation by maternal recognition and is nurtured on the quality and consistency of the parental style of upbringing. Thus identity is in a sense an outgrowth of all the earlier stages; but the crucial period for its development to maturity comes with the adolescent crisis.

Every adolescent is apt to go through some serious struggle at one time or another. The crises of earlier stages may return in some form as he seeks to free himself from the alignments of childhood because of both his own eagerness for adulthood and the pressures of society. For a while he may distrust what he once trusted implicitly; may be ashamed of his body, and doubtful of his future. He experiments, looking for affirmation and recognition from his friends and from the adults who mean most to him. Unconsciously, he revamps his repertory of child-

hood identifications, reviving some and repudiating others. He goes in for extremes—total commitments and total repudiations. His struggle is to make sense out of what has gone before in relation to what he now perceives the world to be, in an effort to find a persistent sameness in himself and a persistent sharing of some kind of essential character with others.

Far from considering this process to be a kind of maturational malaise, a morbid egocentricity of which adolescents must be "cured," we must recognize in it the search for new values, the willingness to serve loyalties which prove to be "true" (in any number of spiritual, scientific, technical, political, philosophical, and personal meanings of "truth") and thus a prime force in cultural rejuvenation.

The strengths a young person finds in adults at this time—their willingness to let him experiment, their eagerness to confirm him at his best, their consistency in correcting his excesses, and the guidance they give him—will codetermine whether or not he eventually makes order out of necessary inner confusion and applies himself to the correction of disordered conditions. He needs freedom to choose, but not so much freedom that he cannot, in fact, make a choice.

In some adolescents, in some cultures, in some historical epochs this crisis is minimal; in others it holds real perils for both the individual and society. Some individuals, particularly those with a weak preparation in their preceding developmental crises, succumb to it with the formation of neuroses and psychoses. Others try to resolve it through adherence—often temporary—to radical kinds of religious, political, artistic, or criminal ideologies.

A few fight the battle alone and, after a prolonged period of agony characterized by erratic mood swings and unpredictable and apparently dangerous behavior, become the spokesmen of new directions. Their sense of impending danger forces them to mobilize their capacities to new ways of thinking and doing which have meaning, at the same time, for themselves and their times. In my book "Young Man Luther" [5] I have tried to show how identity is related to ideology and how the identity struggle of one intense young genius produced a new person, a new faith, a new kind of man, and a new era.

I think I chose to write about Luther and his time because there are many analogies between our time and his, although today the problems which beset all historical crises are global and, as it were, semifinal in character. Today, throughout the world, the increasing pace of technological change has encroached upon traditional group solidarities and on their ability to transmit a sense of cosmic wholeness and technological planfulness to the young.

To me one of the most disturbing aspects of our technological culture is the imbalance between passive stimulation and active outlet in the pleasures that are sanctioned for young people. With the passing of the western frontier and the accelerated appearance of automatic gadgets, young people have become increasingly occupied with passive pursuits which require little participation of mind or body—being conveyed rapidly through space by machines and watching violent fantasies at the movies or on television—without the possibility of matching the passive experience with active pursuits. When an adolescent substitutes passivity for the adventure and activity which his muscular development and sexual drives require, there is always the danger of explosion—and I think that this accounts for much of the explosive, unexpected, and delinquent acts on the part of even our "nice" young people.

This is probably why "Westerns," always on the borderline of the criminal and the lawful, capture the passive imagination of a youth which has traditionally substituted identification with the rugged individualist—the pioneer who ventures into the unknown—for commitment to a political ideology; and which now finds itself confronted with increasing demands for standardization, uniformity, and conformity to the rituals of a status-convention. While the national prototype has historically been based on readiness for change, the range of possibilities of what one might choose to be and of opportunities to make a change have narrowed. To this has been added most recently the rude shaking of the once "eternal" image of our Nation's superiority in productivity and technical ingenuity through the appearance of Sputnik and its successors.

Thus one might say the complexity of the adolescent state and the confusion of the times meet head on.

However, I believe that the "confusion" derives from a hypocritical denial of our true position, both in regard to obvious dangers and true resources. When youth is permitted to see its place in a crisis, it will, out of its very inner dangers, gain the strength to meet the demands of the time.

Clinical experience with young people has, it is true, verified that combination of inner and outer dangers which explains aggravated identity crises. On the other hand, it has convinced me and my colleagues, even in hospital work, of the surprising re-

sources which young people can muster if their social responsibilities are called upon in a total environment of psychological understanding.

Question: *Does this kind of confusion have anything to do with juvenile delinquency?*

I would not want to add here to the many claims concerning distinct and isolated causes of juvenile delinquency. But I would like to stress one contributing factor: the confused attitudes of adults—both laymen and professionals—towards the young people whom we, with a mixture of condescension and fear, call teenagers.

Except perhaps in some rare instances of congenital defects resulting in a low capacity to comprehend values, juvenile delinquents are made, not born; and we adults make them. Here, I am not referring to their parents exclusively. True, many parents, because of their own personalities and backgrounds, are not able to give their children a chance for a favorable resolution of the identity crisis. Nor am I referring to the failure of society at large to correct those blights on the social scene—such as overcrowded slums and inequality of opportunities for minority groups—which make it impossible for tens of thousands of young people to envisage an identity in line with the prevailing success-and-status ideology.

Rather I am referring to the attitudes of adults—in the press, in court, and in some professional and social institutions—which push the delinquent young person into a "negative identity," a prideful and stubborn acceptance of himself as a juvenile delinquent—and this at a time when his experimentation with available roles will make him exquisitely vulnerable (although he may not admit or even know it) to the opinions of the representatives of society. When a young person is adjudicated as a potential criminal because he has taken a girl for a ride in somebody else's car (which he intended to abandon, not to appropriate), he may well decide, half consciously, of course, but none the less with finality, that to have any real identity at all he must be what he obviously *can* be—a delinquent. The scolding of young people in public for the indiscretions they have committed, with the expectation that they show remorse, often ignores all the factors in their histories that force them into a delinquent kind of experimentation. It is certainly no help toward a positive identity formation.

In his insistence on holding on to an active identity, even if it is temporarily a "negative" one from the point of view of society, the delinquent is sometimes potentially healthier than the young person who withdraws into a neurotic or a psychotic state. Some delinquents, perhaps, in their determination to be themselves at all costs and under terrible conditions have more strength and a greater potential for contributing to the richness of the national life than do many excessively conforming or neurotically defeatist members of their generation, who have given up youth's prerogatives to dream and to dare. We must study this problem until we can overcome the kind of outraged bewilderment which makes the adult world seem untrustworthy to youth and hence may seem to justify the choice of a delinquent identity.

Actually, transitory delinquency, as well as other forms of antisocial or asocial behavior, often may be what I have called a *psychosocial moratorium*[4]—a period of delay in the assumption of adult commitment. Some youths need a period of relaxed expectations, of guidance to the various possibilities for positive identification through opportunities to participate in adult work, or even of introspection and experimentation—none of which can be replaced by either moralistic punishment or condescending forgiveness.

Question: *The theme of the 1960 White House Conference on Children and Youth charges the Conference with studying and understanding "the values and ideals of our society" in its efforts "to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity." On the basis of the scheme which you presented to us in 1950, could you add a word about how these values, once identified, can be transmitted in a way that will insure their incorporation into the value systems of the young?*

Like every other aspect of maturity the virtues which we expect in a civilized human being grow in stages as the child develops from an infant to an adult. What is expected of a child at any time must be related to his total maturation and level of ego-strength, which are related to his motor, cognitive, psychosexual, and psychosocial stages. You can't expect total obedience from a 2-year-old who must test a growing sense of autonomy, nor total truth from a 4-year-old involved in the creative but often guilt-ridden fantasies of the oedipal stage.

It would be in line with the course of other historical crises if in our Nation today a certain sense of

moral weakness were producing a kind of frantic wish to enforce moral strength in our youth with punitive or purely exhortative measures.

Today, a sense of crisis has been aggravated by the long cold war and the sudden revelation of the technical strength of a supposedly "backward" rival. We are wondering whether we have made our children strong enough for living in such an unpredictably dangerous world. Some people, who suddenly realize that they have not been responsible guardians of all the Nation's young, now wonder whether they should have beaten moral strength into them or preached certain absolute values more adamantly.

No period, however, can afford to go back on its advances in values and in knowledge, and I trust that the 1960 White House Conference will find a way to integrate our knowledge of personality development with our national values, necessities, and resources. What we need is not a plan whereby relatively irresponsible adults can enforce morality in their children, but rather national insistence on a more *responsible* morality on the part of adults, paired with an *informed* attitude toward the *development* of moral values in children. Values can only be fostered gradually by adults who have a clear conception of what to expect and what not to expect of the child as, at each stage, he comes to understand new segments of reality and of himself, and who are firm about what they are sure they *may* expect.

It must be admitted that psychiatry has added relatively little to the understanding of morality, except perhaps by delineating the great dangers of moralistic attitudes and measures which convince the child only of the adult's greater executive power, not of his actual moral power or true superiority. To this whole question, I can, on the basis of my own work, only indicate that the psychosocial stages discussed in 1950 seem to open up the possibility of studying the way in which in each stage of growth the healthy child's developmental drives dispose him toward a certain set of qualities which are the necessary fundaments of a responsible character: in *infancy*, hope and drive; in *early childhood*, will and control; in the *play age*, purpose and direction; in the *school age*, skill and method; and in *adolescence*, devotion and fidelity. The development of these basic qualities in children, however, depends on the corresponding development in adults of qualities related to: in *young adulthood*, love, work, and affiliation; in *adulthood*, care, parenthood, and production; and in *old age*, "wisdom" and responsible renunciation.

Now I have given you another set of nice words, throwing to the winds my own warning regarding the way they can be misunderstood and misused. Let me point out, therefore, that I consider these basic virtues in line with our advancing psychoanalytic ego-psychology, on the one hand, and with our advancing knowledge of psychosocial evolution, on the other, and that the conception behind this list can only be studied in the context of advancing science. I will discuss this further in a forthcoming publication,[6] but I mention it now because I thought I owed you a reference to the way in which my contribution of 1950 has gradually led me in the direction of the great problem of the anchoring of virtue in human nature as it has evolved in our universe.

We ought to regard the breaking of a child's spirit—by cruel punishment, by senseless spoiling, by persistent hypocrisy—as a sin against humanity. Yet today we have back-to-the-woodshed movements. Last year in the legislature of one of our greatest States a bill was introduced to allow corporal punishment in the public schools and was lauded by part of the press. This gave the Soviets a chance to declare publicly against corporal punishment, implying that they are not sufficiently scared by their own youth to go back on certain considered principles in the rearing of the young. Actually, I think that we stand with the rest of the civilized world on the principle that if adult man reconsiders his moral position in the light of historical fact, and in the light of his most advanced knowledge of human nature, he can afford, in relation to his children, to rely on a forbearance which step by step will bring the best *out* of them.

The 1960 White House Conference comes just in time.

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[1] Erikson, Erik H.: Childhood and society. W. W. Norton & Co., New York, 1950.

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*The States and national voluntary organizations report to the 1960 White House Conference on conditions, problems, and needs of . . .*

# TODAY'S CHILDREN AND YOUTH

## I. As Viewed from the States

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THE SIXTH White House Conference on Children and Youth will be meeting in Washington March 27 to April 2; 7,000 people concentrating their strength to promote opportunities for children and youth "to realize their full potential for a creative life in freedom and dignity."

In addition to each conferee coming to Washington are many thousands of citizens who have spent the past year studying and discussing the needs of children in their communities. They have done these things under the stimulation and the direction of a committee designated by the Governor of their State to prepare for the 1960 White House Conference.

The multiple studies and reports of the think-sessions within each State have been incorporated into a State report for the White House Conference. Copies of the State reports were sent to the Conference staff in Washington last fall and are the basis for a summary volume of State reports, an official White House Conference publication. These reports have the earth of America in them, the mud and the nurturing soil; the sunlight and the darkness; the sureness of dawn.

They do not come up with startlingly new knowledge or recommendations—in most instances what they recommend has been heard before from professional and technical groups dealing with health problems, adoptions, court programs for juveniles, dependency, and neglect, and from previous White House Conferences. They reflect, however, review of the total environment of all children rather than intense focus on any single aspect of the environment or any particular group of children. They evidence earnest stocktaking, adding up to a useful catalogue of unmet needs on which to base future programs. The significance is that even though they recognize that their recommendations mean more taxes, more coordination, and the sacrifice of vested interests, the citizen groups are making them to themselves—for action in counties and local communities and for mobilization for appropriations or other legislation necessary from the State and the Nation. The reports present a challenge to local and State governments, church groups, health and welfare agencies, community and State organizations, and the Nation as a whole to bestir themselves on behalf of children.

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These two articles are based on the authors' reviews of the reports submitted by the States and national organizations to the Golden Anniversary White House Conference on Children and Youth. However, they are not official statements of the Conference, and responsibility for the selection and summary of materials rests with the authors.

Two volumes reporting more fully on the contents of the States' and national organizations' reports, being published by the Conference, will be available at the end of March 1960.

In most instances, the reports reflect the panorama of the society in which children are growing up: the impact of population increase and of mobility, of higher family income, of the invasion of the home by TV; an apparent lowering of moral and ethical standards among adults; increased church attendance; the prevalence of "going steady" among adolescents; early marriages; the economic necessity for young people to have at least a high school education; the nearness of the bigger world of jets and sputniks.

Occasionally a wisp of nostalgia creeps in—for the days of the woodshed and the chaperon. But few reports look backward. The prevalent view is that just around the corner—if we pool our resources, coordinate our efforts, push our research into practice, find the money and the trained staff—the good era is ahead.

The reports show faith in the democratic process, in today's young people, in the vigor of America. South Carolina writes: "Fortunately our youth are ahead of us in adjusting to changing situations. Like young people everywhere they accept change more readily than their parents . . ."

And a junior high school student tells a group of parents: "Give us that extra margin of time to forget the games of childhood and learn the game of life . . . We need you for leadership and guidance but you need us, too, for if there is to be a tomorrow, it will rest in our hands . . ."

### *How the Reports Were Prepared*

The preparation of the reports within the States had all the ingenuity and variety characteristic of the democratic process. Most of the State committees, as a first step, set up factfinding committees which brought together background information—economic, social, demographic—relating to family life, and developed guides for use by county committees and other groups.

The county committees made local surveys, held countywide conferences, and sent reports on findings and recommendations to the State committee where the factfinding committees analyzed them along with reports prepared by Statewide organizations concerned with special areas of interest. The draft report thus developed was then, in most States, presented to a conference of several hundred persons for discussion in work groups and plenary sessions for revision and approval before being sent to Washington. Many county committees have published and distributed their reports and recommendations locally. All the State reports are being given wide distribution.

Some school children of the 50th State, with their teacher. They and the rest of Hawaii's 250,000 children under 21 will be represented by 30 State delegates at the Conference.

There were many variations in the fact-finding methods. Questionnaires and public opinion polls were used extensively along with discussion groups, committee meetings, panel presentations, and surveys. Texas, for example, combined a wide range of techniques for assessing citizen thinking. Fact-finding committees prepared questionnaires which were widely distributed. Youth's needs were elicited by public opinion polls through 625 newspapers, the Future Farmers of America, and the State pharmaceutical society, which caught the drugstore crowd. Sixty-two percent of the replies identified lack of adequate parental care and guidance, including spiritual training, as the great problem. The second highest item—9 percent—was lack of educational opportunities. Because of these returns, a marketing research firm, as its contribution to the Governor's committee, conducted an opinion poll of the views of the general public on what constitutes "adequate parental care and guidance." Fourteen State youth organizations compiled a discussion guide, used by young people in 815 junior and senior high schools (651,000 students) during Youth Participation Week, and by 3,000 units of the State PTA.

The State 4–H and home demonstration clubs made a survey among rural youth. Statewide organizations sent in reports of activities and recom-

mendations. The material from all these sources flowed into the factfinding committees. A preliminary report, with recommendations, was drafted and presented to a Statewide Conference in December. This now becomes the basis of a State program for social action.

While most States used the county as the natural local unit for self-study, some, including California, Minnesota, and Nevada, used the town as the unit. Hundreds of town meetings were held, where opinion was freely expressed and registered as a basis for recommendations. Another self-study unit was the region or district encompassing many counties, as used in Arizona, Louisiana, and Michigan. Whatever the unit, intensive surveys were made, and conferences held to discuss and vote upon reports and recommendations.

Alaska is so spread out and thinly populated that meetings of any appreciable number of persons are virtually impossible. So the State committee used the United States mail and wrote to the mayor of every city, town, and village, many with population of less than a hundred. The responses form the body of the Alaska report, which also includes a review of the characteristics of this new State.

### *Youth Participation*

From the beginning the President's National Committee for the White House Conference on Children and Youth and the National Council of State Committees stressed the importance of fully involving youth in all stages of the Conference. While many State committees were somewhat uncertain about how to achieve this, they found answers from young people themselves. Youth participation committees were formed which worked with the adult groups. They developed, distributed, and processed questionnaires which provided media for thousands of teenagers to indicate what they consider youth's problems today and what to do about them. Local, regional, and State youth meetings provided an opportunity for free discussion.

A 2-day State meeting was held in New York State with 150 high school delegates discussing youth's problems in six workshops moderated by adults. Their recommendations were fused into the State report, and the young delegates followed through by reporting the conference findings at hometown meetings. In Oklahoma, 1,200 students from 169 high schools held a two-day workshop to prepare a statement of needs which was sent back to their schools for discussion and amendments before inclusion in the State report. In Oregon young people took over the house of representatives for one day to discuss youth's problems, relegating the few adults present to the spectators' galleries. At many conferences to consider the State reports, young people led discussion groups and served as panel members, as in Utah, where a youth panel was televised. One half of the delegates at the North Dakota State conference were young people. Youth delegations from Illinois, Minnesota, and Wisconsin met together in October and developed recommendations on orientation for youth participants at the Washington sessions of the Conference and for postconference follow-up action.

The governors of several States gave official recognition to youth participation in preparation for the White House Conference. For example, in Indiana the Governor proclaimed a Youth Day, and in Texas and Utah the Governors proclaimed a Youth Participation Week.

## HIGHLIGHTS FROM THE REPORTS

In many ways the reports reflect the general prosperity of the 1950's. There is almost no mention of poverty, hunger, or evictions occurring, except where there is no adult male wage earner in the family. Unemployment, the black plague of 30 years ago, is not often referred to, except for the serious problems of some of the outlying villages in Alaska and of pocket populations stranded in Appalachian coal mining communities.

Basic income for essentials is reported as a major problem for many of the families in which the mother must be the sole provider. If she is an unskilled worker her wages are low, and direct or hidden costs are increased because of her absence from the home. If she remains at home to rear the children and receives public assistance, in most States the payments are considerably below budget standards for health and decency.

The close interrelationship of employment and family life is highlighted in the concern for working mothers. The majority of State reports reflect a feeling that mothers should not work, if possible. A minority takes another approach, accepting the fact that mothers do work and stressing the importance of measures to protect their children while they are out of the home.

For teenagers, on the other hand, the reports universally express a need for part-time and summer

employment opportunities regardless of family income.

But they also reflect an important area of controversy in whether or not to change the child labor laws to expand work opportunities and to permit young people who drop out of school to choose from a broader range of jobs. Some State reports advocate modification of such laws as a delinquency prevention measure. Other State reports (e.g., from Maine, Wyoming) insist that there is no relation between child labor laws and delinquency. South Carolina wants to strengthen such laws, and places upon the family and the community the responsibility of providing opportunities for adolescents to learn how to work through home chores, after school jobs, and summer employment.

Practically all the State reports stress the fact that the level of training required for jobs is steadily rising, while fewer and fewer jobs are open to unskilled workers. Many express concern for the future of today's farm youth, as the mechanization of farming decreases the need for people on the land. All the States uniformly deplore the lack of sufficient vocational guidance services.

### *Family Life*

The reports are divided between optimism and anxiety as to whether anything good is happening to family life in America. Some reports suggest that the divorce trend is downward; others find it going up. They all make note of early sexual relationships and are worried about both marriages and illegitimate births among teenagers. They indicate an anxious feeling on the part of parents that "we ought to take hold but how do we do it without beating them?" Young people of high school age especially are asking that parents take a firm line and stick to it.

The reports reflect a general feeling—on the part of teenagers as well as adults—that parents should "maximize" the time they spend with their children. They suggest not only that too many mothers are working, but also that some mothers spend too much time on other activities outside the home. Some reflect a feeling that fathers are not spending enough time with their children. Family recreation is called for in many reports.

All the State reports call for family life education, but they mean different things by it—sometimes sex education, sometimes the inculcation of values, sometimes general preparation for marriage through instruction in homemaking, the management of finances and the like. Some want it taught by the schools, some by other community organizations. One State report questions whether family life education does any good, but another—from Illinois, where there are extensive family life education programs—expresses the opinion that parents are showing more confidence as a result.

### *Values and Religion*

Nearly all reports reflect unrest and concern about the kinds of values the adults in our society seem to be inculcating in children. This is paralleled by an uncertainty as to approaches which might shift values from the heavily materialistic toward the less tangible, more intrinsic ideals expressed through terms such as brotherly love, honesty, excellence, self-discipline, recognition of the worth of every individual.

The Ohio report says: "Children need to develop a set of ethical and moral values which will enable them to live in the community with relative stability, purpose, and sense of personal satisfaction . . ." And a youth report: "Spiritual and moral values should be fed to small children and teen-agers just as food is fed, because it is with these tools that they meet other social problems that need solution."

Responsibility for the process of "idealizing our values and strengthening guideposts for our children" is variously assigned to parents (most frequently), the churches, the schools, and the communications media, especially TV.

Two Eskimo children in Alaska. So far apart are the settlements of this largest of the States that much of the activity to prepare for the Conference had to be carried on by mail.

Although the reports are generally hopeful, a growing materialism is mentioned by many with real foreboding. They seem to be saying with Walt Whitman: "It is as if we were somehow being endowed with a vast and thoroughly appointed body, and then left with little or no soul."

Most State reports contain some reference to organized religion, though only a score of them devote a full subcommittee report or section to the role of churches and synagogues in the lives of children and youth. They comment on: (1) a pouring out of money for religious edifices and equipment in the past decade; (2) increasing attendance and activities; and (3) a greater emphasis on religious instruction and less on social activities. Finally, they reflect a sense of uncertainty concerning the role of organized religion in this changing world: How can the spiritual and the secular be reconciled? Young people are confused, they say, by discrepancies in what they hear and what they see.

### *Minorities*

The Supreme Court decision of 1954 is central to the discussion of problems of minority groups in a number of the State reports. However, fewer than 30 deal with these problems at all: several Southern State reports do not—although Alabama's does, and a committee of Negroes in Georgia submitted a separate report; some Northern States with large minority populations faced with many problems, such as Illinois and Pennsylvania, also do not discuss problems of minorities in their reports.

Some reports, such as Kentucky's and Oklahoma's, list gains in desegregation in the schools in the last decade. On the other hand, South Carolina reports the repeal of compulsory school attendance laws.

Report after report comments on the increasing urbanization of minority groups, and on population migrations from south to north, from country to city, from Puerto Rico to the mainland, and to a lesser extent from Indian reservations to the cities.

Some reports show a consciousness of the need for fresh approaches to problems of minorities: one trend is the organization of human relations commissions to deal with racial tensions. Citizen groups are also reported as organizing on a neighborhood basis to retain community standards and values, to prevent panic selling of homes when new groups begin moving in, to help newcomers adjust to the community. Youth groups show not merely willingness but a real earnestness in seeking solutions.

From the point of view of sheer quantity, the reports contain more about American Indians than about any other minority group. The Montana Committee devoted over a third of its report to Indians. This seems to reflect an increasing awareness of State responsibility for extending Indians the same privileges as other citizens and for helping them to become part of the life around them. That Indian tribal councils are assuming broader leadership too is evidenced by their cooperation in New Mexico and Utah with the State White House Conference committees.

### *Juvenile Delinquency*

Most of the State reports include some mention of juvenile delinquency with recommendations for strengthening services for its prevention and treatment. Many discuss it under the heading of broader social disturbances and stress the importance of prevention through expanded programs of recreation, vocational training, child welfare, employment, family life and parent education, and mental health.

The recurrent theme is the urgency of the need for development of preventive and treatment services not now in existence, and for expansion and improvement of inadequate existing services. (Sixteen States report that sometimes children are held in jails regardless of age, sex, or legal restrictions.) Also emphasized is the companion need for more and better coordination of services, both State and local.

The magnitude of the need for services and facilities is indicated by the reiterated references to shortages in trained personnel, funds, and physical facilities in all of the State reports, irrespective of the size of the State, its geographical location, its extent of urbanization, the size of its juvenile delinquency problem, or the degree of development of State and local programs. The reports make clear that even the States that document the need for new and creative approaches and more research, as some do, have not been able to use to maximum advantage already existing knowledge and techniques because of insufficient funds, trained personnel, and facilities for detention, diagnosis, treatment, and aftercare.

### *Education*

The crisis in education is brought up in all the reports: serious shortages in trained teachers, classrooms, and up-to-date equipment, accentuated by a marked population bulge in school-age children. Citizens are asking on the one hand for a stronger academic curriculum, including more foreign lan-

guage (beginning earlier); more and better science, more challenging courses for the gifted, a general pursuit of excellence. On the other hand, they are asking the public schools to provide driver education; vocational training; career counseling; education in the dangers of alcohol, tobacco, and narcotics; sex education; and, especially, preparation for marriage. They want the schools to be responsible for the early identification of children out of the norm—be they gifted, retarded, disturbed, potential delinquents, hard of hearing, or visually handicapped. They also want the schools to provide special classes and specially trained teachers for children who, for whatever reason, cannot easily be taught in the regular classrooms.

The question is how to provide all this, including the additional classrooms needed. The reports include many financial proposals, which seem to boil down to reassessment of local land values, broadening of the tax base, and increased Federal and State participation. Oklahoma, for example, concludes: "Since education is of national concern and there is an inequality in the ability of States to adequately finance education, participation of the Federal Government with the States and school districts is recommended in the financing of public education with only auditing controls of Federal funds by the Federal Government."

### *Children in Special Need*

The overall impression emerging from the reports is that welfare machinery is good but there is a woeful lack of staff and money. In general, all States have something of everything in facilities and services, but the coverage is spotty and inadequate especially in the rural areas, while in the urban areas welfare agencies have not been able to keep up with the needs of growing and shifting populations.

Grants in the Aid to Dependent Children program are still too low—a universal complaint. The reports note some improvement in foster home care—in selection and supervision. Nearly all recommend extension of day care facilities. Some also mention the need for improved licensing standards for both day care and full-time care facilities. Fewer than might be expected express a need for homemaker services. On the other hand the reports indicate a growing awareness of the needs of unmarried mothers as well as improvement in services for them. Institutional care is reported as needed for children with special problems—particularly the severely retarded and the emotionally disturbed.

Practically all the States report a serious shortage both of trained personnel to work with disturbed or handicapped children and of facilities for training personnel. The personnel shortage is aggravated by the fact that trained workers tend to cluster in urban areas and near training centers. This leaves large rural areas badly underserved. Parents and children often have to travel 50 to 500 miles for diagnosis and treatment.

The reports cite a need not only for more clinics for disturbed children but also and especially for residential treatment centers. These are, however, so expensive to build, staff, and maintain—the cost of caring for one disturbed child in such a center may run as high as $800 to $1,000 a month—that the States are hard put to figure out an answer.

Perhaps because of both the expense of caring for disturbed children and increased understanding of mental illness, the reports emphasize the importance of preventing mental illness. They show a trend toward providing mental health services in the schools. A number report State laws requiring or permitting school systems to employ psychologists and social workers who can spot problems of emotional disturbance in children in the early stages and provide appropriate guidance to them, their parents, and their teachers.

The States report a need for more of everything to cope with the problem of mental retardation. They ask for more research, looking toward both prevention and service. They call for more diagnostic facilities to aid in early recognition of retardation; more trained personnel; more special facilities for educable retardates; more facilities for vocational training; more, better, and different types of institutions—such as halfway houses and cottage-type institutions for the moderately retarded who need supervision and a protected environment but not constant help and attention; more planning and coordination of programs; more public information about what facilities are available; more counseling for parents as to available facilities, how to deal with a retarded child in the home, and how to deal with their own emotional problems.

### *Health and Health Services*

The reports show that there is still a shortage of medical care in the United States: in the Plains States and the Southwestern States and in rural areas generally. In Arizona, for instance, pediatric facilities are practically nonexistent in many counties. Infant mortality is still serious in rural areas,

especially in the Southwest. Most of the reports mention the need for more studies of perinatal mortality. Some mention a slight increase in venereal disease among teenagers.

Most of the reports comment on the need for expanding and improving school health services. A great deal of concern is expressed over accidents, especially motor vehicle accidents, as a cause of death and injury among children, particularly adolescents.

In few States do more than three-quarters of the counties have good local health departments. One report—Indiana's—raises the question of whether the classic local health unit—county, multicounty, or city-county—is appropriate in view of present personnel and financial difficulties, or whether some other kind of administrative unit might not be more effective.

The reports suggest the need to increase public awareness of the health facilities and services which are available and to get people to use them, especially for prenatal and infant care. For example, Minnesota reports that only 38 percent of children under 4 have been vaccinated against polio, and this is not unusual.

The reports reflect a considerable interest in dental care, both preventive and remedial. They indicate that remedial care is still unavailable for many children, and not enough dentists are being turned out yearly. The Virgin Islands reports "a shortage of dental supplies, and the dentist often extracts permanent teeth without attempting to fill or otherwise save them." The reports generally recommend fluoridation of community water supplies, and since small communities often cannot afford this measure, a number of them call for Federal and State aid for this.

Many reports express concern over the health hazards of childbearing among teen-age girls who marry before they are even physically fully matured. Many State committees also express concern over the poor nutrition habits of teenagers, especially girls, and over the effects of their poor nutrition on their future children.

### *The Use of Leisure*

Most of the reports underscore the importance of recreation and leisure-time programs. Georgia, for instance, considers the provision of constructive opportunities for the use of leisure time as the number one problem. Many reports indicate an increased interest in county planning for recreation because small rural communities cannot afford separate recreation systems. One Western State reports 2,000 square miles without park or playground facilities. New Hampshire, although a playground for winter sports enthusiasts the Nation over, reports a shortage of winter play facilities for its own young people. Many States report an overloading of recreational facilities in the cities because of populations expanded through in-migration; at the same time some resources are not being fully used because newcomers do not know where or what they are. Thus the reports also stress the need for distributing more and better informational materials about recreational needs and opportunities.

North Carolina, Rhode Island, and Indiana report efforts to prevent the sale of obscene literature to anyone under 18. Nearly all the reports deplore the fact that television does not meet its potential as a recreational and educational medium for children. However, Alabama reports 3 State-owned TV channels with programs of an educational and cultural nature.

### *Interrelated Program Planning*

The crying need, highlighted in all the State reports, is the coordination of effort between all agencies, public and private, in all aspects of programs affecting children and youth. At the same time the reports contain innumerable illustrations of cooperative activities. The Governors' committees for the White House Conference with cross-sectional statewide representation are the epitome of just such coordination.

The experience of working together to assess the achievements and the remaining unmet needs in all areas of child life has been so rewarding to the participants that practically every report recommends a coordinating committee on a continuing basis. In most States followup planning is far advanced for the implementation of their own recommendations and those of the Golden Anniversary White House Conference on Children and Youth soon to come.

# TODAY'S CHILDREN AND YOUTH

# II. As Seen by National Organizations

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ABOUT 550 national voluntary organizations are participating in the 1960 White House Conference on Children and Youth. Roughly one-third of the total represent churches, synagogues, and organizations related to them; about one-eighth relate to health; one-eighth to education; the remainder spread across many fields of activity affecting children and youth, such as recreation, correction, human relations, labor, community organization. Some are devoted to research in special subjects important to the growth of children, others concentrate on the promotion of social legislation, or on participation by children and youth in community and international programs.

Whatever the focus, the pattern of voluntary organization on the basis of interest and conviction is obviously an essential aspect of the American style. In what other way could the views of important parts of our society find effective expression? Political channels are too narrow to carry the flood. Nevertheless, in every area of child life and youth experience the efforts of voluntary organizations have little long-range vitality unless they have found or can create firm points of reference, interest, and support within the fabric of government, including constitutional guarantees, both State and Federal. Conversely, the efforts of government may wither on the statute books unless they arouse a positive response among interested citizen groups in the field dealt with.

The White House Conferences throughout their history have afforded good examples of the union of governmental and nongovernmental forces, with a strong infusion of the opinions of nonprofessional citizens and, in the 1950 and 1960 Conferences, of youth itself.

Over 100 of the national organizations taking part in the current Conference have reported on their aims and programs. The aim of this article is to present a brief account of some of the main achievements, difficulties, and hopes expressed by the reporting organizations.

### *The Use of Resources*

The reports show considerable concern about the use of resources: money, manpower and womanpower, materials, and facilities. These are all interrelated, and all are sources of concern to voluntary organizations. They make it clear that more money will need to be spent from public and private funds for all sorts of things—education, recreation, housing, trained leadership, research. But they also show that money will not do it all; the motivation of professional and volunteer workers and their training and status are important too. Some organizations look to retired personnel for help in relieving shortages; some seek it in the education of more young people for professional or nonprofessional roles in directing the activities of children and other youth. Coordination and cooperation among organizations themselves, and in relation to government, are important elements in conserving resources. Progress is reported in this respect by leading professional organizations and by those concerned with identifying needs and aligning facilities and staff, both professional and volunteer, to meet them. The reports make clear that still further progress is required to meet the challenges of our changing communities.

As to facilities, the reports emphasize, in addition to the well-publicized lack of schoolrooms, the need for more action to supply the kind of environment



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Two first graders. How to increase the quality of educational opportunities for these and other children concerns a number of national organizations reporting to the Golden Anniversary White House Conference on Children and Youth.

conducive to child welfare and health and to a creative life for children and youth. This last point is stated as an urgent matter in the crowded metropolitan regions. Though remote areas do not suffer from pressure of population, it is acknowledged that they too have problems of inadequate services and facilities.

### *The Family*

The reports reflect a renewed focus of interest on family life on the part of many organizations. One of the reasons for this may be found in the numbers of broken or unstable families that have come to their attention. Other reasons may be that general institutions and organizations in religion, education, medicine, and welfare find that the performance of their roles depends on parental understanding and cooperation. The reports bear testimony to the fact that where families exist with one parent or none, or where both parents are out of the home for a large portion of the day, the community institution has many duties thrust upon it. But when families are whole and in reasonably good condition, the established impersonal forces find that religion, knowledge, manners, health, and many other elements of positive good do not flower without cultivation in and by the family.

Thus the reports show signs that organizations in basic fields of work with children and youth are in a way talking back to American parents. They are saying in effect that developing the full potential of children and youth depends on the families that created them or have taken responsibility for them.

On the other hand, many of the organizations seem to be telling themselves that if the family institution retains such basic importance, then there must be increased emphasis on educating youth and young men and women in the breadth and depth of responsibility belonging to marriage and parenthood and in forming realistic expectations of what family life can mean to them. They show alertness to the divisive forces at work, besides faulty personal attitudes, such as different employment schedules of both father and mother, and different social schedules of parents and children. But they do not contemplate or foresee a change in these conditions. Rather they seek ways to support and enrich the life of our most rugged and fundamental institution, the family. This support comes in various forms, such as the further development of day care for children of working mothers and the expansion of family counseling services.

### *Religious Faith*

In their reports many organizations show a common-sense realization of their own and society's limitations and frustrations, and of the doubts and dangers inherent in a period of conflict and innovation. But they also express a preoccupation with perfection—attributable in part no doubt to a rationalist tradition in social and scientific theory, but also a great deal to religious conviction and idealism. Such conviction is reflected not only in reports on the direct operations of church and synagogue but also in those on other social undertakings strongly influenced by religious thought, aspiration, and example.

The same kind of motivation that has led church and synagogue into many fields of social enterprise and action—camping, recreation, hospital work, health education, and others—has stimulated the founders and the succeeding directors of youth organizations and other community organizations of different types. The reports show that much work for and with children and youth, and many organizations and programs involving them, are as strongly influenced as ever by religious idealism and the sense of worship, and that this influence promises to remain strong in our society for years to come.

The reports bear testimony to the fact that in re-

cent years many churches and synagogues through official announcements and planned social activity have championed the dignity of the individual both in regard to civil rights and social opportunities. They also show that religious organizations have taken various positions on how religious instruction should be given and on who should pay for it outside the family circle. They make clear that, however this question may be resolved, there is no doubt that religious considerations will continue to influence the secular learning of children and youth, as well as their moral and spiritual insight.

### *Education*

Reports from the professional educational organizations, as well as others, reflect the intensity with which the education of children and youth has been debated throughout the past decade. This debate was accelerated by the 1954 decision of the Supreme Court outlawing racial segregation, and by the scientific achievement of the U.S.S.R. signalized by the launching of Sputnik. Complicating factors in the discussion reflected in these reports were: rising costs, increased numbers of youth in schools and colleges, and limitations on facilities and on the number of qualified teachers at all levels.

Some of the major criticisms of education reported are that we have not identified gifted young people early enough, that we have overlooked many of them; that general education in basic fields of scientific learning has not been rigorous enough; that we teach an inadequate number of foreign languages, in the wrong way; and that schools, especially public schools, spend time and money on subjects that, whatever their importance otherwise, should not be important in the curriculum.

But the reports also indicate that the sharpened discussion of educational issues has had good results, not only in heightened public awareness of their importance but in renewed attention to improved opportunities for student progress in mathematics, science, and languages. They indicate that an increased effort is being made to identify and to assist gifted youth in their education, by action of private organizations and through the operation of the National Defense Education Act, although some reports question some provisions of the act.

At the same time they show an awareness that those persons responsible by law for the direction of teaching and learning, and those nonprofessionals who are responsible by election and conscience, will continue to face the question of balancing the content of teaching in relation to total needs demonstrated or expressed in our society. Democratic living, economic survival, health and safety, esthetic expression and appreciation, international relations are but a few of the general fields in which these reports demand that salient elements be translated into the curriculum. They are concerned with helping each child learn what society requires him to know for social and economic survival, and for a productive way of life. The reports show how organized education, on the theory that if education is for all, then it is for each, is attempting to apply itself to fulfilling the potentials of both extremes of the learning scale as well as of all individuals in between.

Various reports indicate improvement in the quality and status of teacher education, in recruiting for the profession, and in general educational opportunity through the continued consolidation of school districts. Progress is reported for some regions with respect to racial desegregation in the schools, along with the hope that local opinion will permit further resolution of this unsolved problem. Widely differing views are expressed in the degree to which public funds should be used in support of private institutions, especially those administered by religious bodies. In regard to the more general issue of increased support to education by the Federal Government, the weight of organizational argument in the reports favors such support.

### *Health and Safety*

Reports indicate that the health, both physical and mental, of our children and youth is generally good, and the overall trend is favorable. However, it is reported that infant mortality, after declining for a long period, rose slightly in 1957 and 1958, the possible causes being now under study. Furthermore, the reports point to the need for new victories in such special fields as cancer research.

Also reported is a need for greater education and motivation of parents, children, and the whole community to reduce accidents among young people. Accidents kill more young children than any single disease, while in the older age group the rate is higher than from all other causes combined. Some organizations report that this older age group, which includes high school youth, college students, and young workers, has both nutritional and emotional problems, owing to changes in schedules of living and working and to the pressures to which they must adapt themselves. Continued health education is

planned in schools, colleges, industry, and community to improve this situation.

Another field of effort suggested for renewed concentration is in the prevention and control of venereal disease, especially among adolescents, among whom the incidence has increased, especially in large urban centers, during the last 5 years. Organizations report working with public authorities toward better family supervision and control, improved sex education, and more thorough reporting of cases by physicians.

In regard to children who have physical, mental, or emotional handicaps the organizations report that much progress has been made in the provision of therapy, and of special educational arrangements. Some progress, though not enough, is reported in achieving the acceptance for various types of employment of physically handicapped young people who are able to work.

The reports also reflect increased efforts to identify in children while they are very young any tendencies that might develop into serious mental, emotional, or psychological conditions. School authorities, community services, churches, families, and many interested professions are reported to be involved in a human conservation program which in its various aspects may be called mental health, therapeutic action, and social understanding; but the demands for help exceed the supply of practitioners and special treatment facilities. This is also reported as true of efforts for the mentally retarded.

Marked progress is reported to have occurred during the past decade in research and in improved professional and community organization to promote the well-being of children who are in any way handicapped. The organizations give promise of redoubled efforts to advance research, to train the trainable, to educate the educable, to employ the employable, to protect those who can offer nothing in return, and of continued efforts to help families accept, understand, and aid their own children who are retarded or defective.

### *Work and Leisure*

The goals of personal and social freedom, of individual dignity, and of creative experience are clearly expressed in the reports of organizations which work with children of preschool and elementary school age. These goals become more confused in reports concerned with older youth, partly because of the variations in young people's personal growth and aims, partly because of the lack of clarity with which adults' expectations of youth are sometimes stated, and partly because opportunities for vocational and avocational creative work experience are denied.

Labor laws protecting children are reported to have done their work well except for certain groups such as the children of agricultural migrants. But the reports also show that economic unemployment among adolescents is high and that lack of opportunity for constructive occupation in a general sense remains serious for school dropouts and for high school and college youth in vacations or outside of school hours. A great investment of effort is reported by schools, community organizations, and other groups to devise expedients that will be attractive to youth and will result in creative and useful occupation. On the other hand, some organizations emphasize the need to resist pressures toward early career commitment. Some suggest that the increase in the youth population will compel a revision in our methods of introducing young people to the work of the world, as well as in the values we place on the various ways of employing leisure time. The wellsprings of vitality, ambition, and ability among youth are seen as far from dry.

### *Personal and Social Development*

As national organizations state their concerns, a large number of questions converge to form a single question as to how well our children develop into self-dependent persons who have a sense of social function, interrelation, and responsibility. Many organizations which influence the family—the school, the church and synagogue, and organized youth groups—indicate a fair measure of achievement. They express concern, however, over the degree to which further ways can be opened for young people to pay into the community such skills as they have attained, so that they may grow through concrete experience and feel that they have a personal stake not only in themselves but also in the fate of the Nation and the world.

Organizations in education, religion, and group-work occasionally indicate conflict or competition in programing for this purpose, thus indicating a need for better coordination. They also report that where adult leadership is interested and informed a great measure of constructive participation is attainable by children and youth in programs of community betterment, local service, international relief, and international relations; but that where such leadership is not in effect, younger citizens are often cut off from the possibility of creative social action.

Certain lines of social division are reported as inhibiting to social growth, including the mutual hostility between the adult world and young offenders against the law and social order. The reports contain no precise means for forestalling or curing juvenile delinquency, though many are concerned with combating conditions and states of mind that apparently result in antisocial behavior. Better guidance in home and school, better means of identifying predelinquents, more adequate assistance to juvenile courts, and better provision for parole and probation officers are some of the points of concentration.

Another social cleavage is reported in relationships between majority and minority groups. Improved living conditions and general status have been achieved by some members of the minority groups dealt with in the national reports—chiefly Negroes, Puerto Ricans, Mexican-Americans, and American Indians. But the reports reveal a great deal of unfinished social and economic business in regard to minorities. Some of the points where greater concentration of effort is reported as needed are in relation to housing, employment, health and education, and direct communication between majority and minority groups. These points are seen as related to the development of higher standards of interpersonal and intergroup relations in general, an objective reported by many groups active in organized education, religious life, and community relations.

Difficulties are reported by organizations of many types in helping children and youth to achieve a sound sense of personal and social identity and responsibility in the face of social cleavages and changing social expectations. There is common agreement on the need for counteracting the adverse forces in the changing environment, so that human values can be reaffirmed and the sense of community created.

Some organizations report recent activities that show some progress in improving intercultural relations among youth, in willingness of adults to accept youth as civic partners, in research for adjusting youth programs more closely to youth needs, and in programs designed to increase international understanding.

Community agencies do not assume that a homogeneous society could or should exist in this country, but they have apparently been compelled to see that there are many cleavages in attitude derived from ethnic background, cultural heritage, and other factors existing in the adult society, which are perpetuated to a more or less intense degree in youthful society. Today when more people live closer together than ever before, organizational leaders seem to realize that it is particularly important for religious, ethical, and practical reasons, to reenforce the sense of a common citizenship within a common humanity.

### *Aid to Families*

The ultimate aim of many organizations is to help families and the younger generations to arrive at a point of economic and psychological self-dependence. The immediate aim often has to be one of amelioration, protection, or support for considerable numbers who cannot sustain themselves without help.

During the past decade many national organizations supported moves to increase and extend the insurance benefits available under the Federal old-age and survivors insurance program as well as the payments made to the needy under the federally aided State public assistance programs, especially aid to dependent children, and to extend the federally aided child welfare services. Many of these organizations now urge further extension of these programs, especially where children are concerned, on the grounds of the inadequate size of insurance benefits and assistance payments in relation to costs of living, the increasing need for services to families and children arising from the growing complexity of the social problems of our day, and the increases in child population. The aid to dependent children's program is especially singled out as in need of improvements, both in the amount of payments available to the families who must subsist through it and in the services available to them for strengthening family life and achieving self-dependence. In the

The major part of the May-June issue of CHILDREN will be devoted to reporting the Golden Anniversary White House Conference on Children and Youth, to meet in Washington March 27 to April 2. The issue will include, among other features: a reporter's story of the Conference; a youth's-eye view by a youth participant who is a member of the executive committee; a summary of the major recommendations; and a report of followup plans by the chairman of the followup committee.

belief that the needs of the child should be the first consideration in these programs, a number of organizations expressly report their opposition to proposals to withhold aid from families containing illegitimate children.

The reports note the effect of State residence laws in inhibiting assistance to families in need and present three approaches to solving the problem: the modification of State laws and regulations; the formulation of interstate reciprocal compacts; and amendments to Federal laws regulating programs of Federal aid. By such reforms, organizations hope to see improvement not only in the provision of financial assistance and services to the financially needy, including agricultural migrants, but also in the extension of medical care and other needed services to unmarried mothers.

The reports especially express concern about "multiproblem" families and the need for breaking the cycle of dependence, involving such domestic and social disasters as desertion, delinquency, alcoholism, or mental illness. They report on community efforts to provide services to troubled families and children, to provide adequate foster care for children who need it, to expand opportunities for adoption, and to extend specialized institutional care for children with special needs.

A few organizations, particularly the legal and judiciary, report on adverse effects on parents and children resulting from the confusion among State divorce laws. They also point to a need for social work assistance to judges in relation to divorce cases. Others report the provision of counseling services, through local affiliates, directed toward helping parents who are in conflict and in advising parents of broken families on problems related to rearing their children.

Because of the large numbers of working mothers of young children, a number of organizations urged an increase in the provision of day care services through the coordination of public and private resources.

### *Individuals*

Generally these reports leave the impression that mature citizens are amazed by the world that has developed around them. They seem disposed to believe that the changes they wish today's children to survive will be more rapid and more revolutionary than what they themselves have known. They do not wish children to be steeped in a ruthless devotion to self, nor to be ironed out into flat servitude to the social machine. They desire for the next generations, as they have desired for themselves, all the freedom, dignity, and creative life obtainable.

These are high aims, holding important elements of religious, democratic, and intellectual aspiration. The aspiration can be transmitted more easily than the achievement, for that has to be reconstructed within each person and each generation.

Out of their own experience the leaders of national organizations have sketched some of the places where freedom, dignity, and the possibilities for creative living are in danger of erosion.

Their reports show that there is still too much want in a rich society; that many individuals need public and private assistance, that chronic dependence needs to be decreased if freedom and dignity are to be realized by everyone. They indicate that the new world may be hard for individuals, including those fixed within a day-by-day pattern of work that is careless of the individual fate, because of the technological demands of business, industry, government, and social organization. They show that to develop the very gifted, the moderately intelligent, and those who are less or least talented, and to see that each reaches a point of self-fulfillment is a serious task for the Nation.

For these reasons, these reports indicate, an unusual effort must be made to interest the individual in active and productive enterprises beyond the limits of his vocation, as well as helping him define his place in the complex patterns of our economy. This is more than a matter of playing fields and other facilities, important as these are; it is a matter of attachment to basic skills, social practices and needs, arts, and fields of knowledge so that the individual, and society through him, will know continual enrichment. The odds are considerable, but as these reports indicate, the prize for the individual is so great that many forces in our Nation are intent on winning the game for him. The prize is not "security" except in the sense of growth in self-knowledge and in just and humane relations. It is, rather, personal achievement of freedom, dignity, and a creative life.

We are at a point where we and our organizations must ask ourselves the question again, and many times over: Do we believe in the individual? Completely? Taking the Nation and the world as they are and will become, how do we deliver the goods?

# MODIFYING SMOKING HABITS IN HIGH SCHOOL STUDENTS

DANIEL HORN, Ph. D.
*Director of Program Evaluation, American Cancer Society, New York*

FIVE YEARS AGO the Public Health Cancer Association officially recognized that the time had come to initiate educational activities applying the scientific findings of the many studies which have revealed an association of smoking and lung cancer. The American Cancer Society can now report experiments in how to modify the smoking behavior of high school students.

During the interval the epidemiological problem changed from "Does smoking cause lung cancer?" to "What is the mechanism whereby cigarette smoking causes lung cancer?" And the educational problem changed from "*Shall* we tell them?" to "*What* shall we tell them?" and "*How* shall we tell them?"

In order to answer this last question we knew first that we needed more information about (1) the amount and pattern of smoking among school students, (2) the factors that distinguish smokers and nonsmokers in this group, (3) the motivations that are common in the taking up of smoking, and (4) the approaches that might be most effective in influencing smoking behavior.

A full description of the study we conducted to collect this information is given elsewhere.[1] The study has included the following aspects:

**1.** At the beginning of the school year a questionnaire on smoking habits and personal background, to be answered anonymously, was administered to all the high school students in the 11 public high schools and 5 Catholic parochial high schools in Portland, Oreg., and in 5 high schools in 2 counties outside the city limits but part of the urban area.

**2.** On the basis of this first questionnaire, 19 of the 21 schools were divided into 6 experimental groups ranging from 2 to 4 schools in number and matched as closely as possible for frequency of smoking among the students.

**3.** One of the six experimental groups served as a control, and no special educational activities in regard to smoking were undertaken in it during the course of the year that would not have taken place anyhow. The other five groups were approached three times during the course of the year with educational materials—pamphlets, flyers, and posters. Through these materials each group was subjected to a different approach. These were:

**Contemporary:** Emphasis on those aspects of smoking having current meaning to high school students.

**Remote:** Emphasis on the relationship of cigarette smoking to lung cancer, especially in later life. The contemporary and remote approaches were included to test which was the more effective as previous interviews with young people had shown that the more immediate effects of smoking are frequently reported as reasons for not smoking, while projective materials tended to show underlying concern with the remote effects.

**Both-sided:** Since some studies of communication indicate that messages dealing with both sides of a question may be more effective for the uncommitted than one-sided messages, this approach was designed to be somewhat permissive in regard to smoking.

**Authoritative:** Since smoking is sometimes an act of rebellion against authority, this was included to test the appeals to authority that are common in most health education messages.

**Adult role-taking:** Since smoking may be a symbol of being "grown up," this approach was designed to let the high school student reverse the usual parent-child roles and become the person who provides information on health (i.e., the lung cancer-smoking

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Based on an address delivered at a session of the Public Health Cancer Association at the 1959 annual meeting of the American Public Health Association.

relationship) to the adults within the family circle.

4. Near the end of the school year the questionnaire was again administered to all the students of the same high schools. The first portion of the questionnaire on smoking habits was identical with that used 8 months earlier. Some changes were made in the second portion as a result of the findings of the first questionnaire.

### *What Makes a Smoker*

Through this study we have identified three factors which distinguish high-smoking from low-smoking groups of students:

1. The most important, is whether or not the parents or older siblings smoke. What seems to matter is whether or not smoking is accepted by the family as a normal and expected form of behavior. When it is, smoking becomes to younger members of the family a part of growing up. This factor accounts for nearly half of the smoking among the students in our Portland survey.

2. We noticed a syndrome of intercorrelated factors that seem to have in common the failure to achieve peer-group status or satisfactions. Smoking is high among young people who have fallen behind their age equals in school, who do not participate in extracurricular activities, and who are taking the scholastically less demanding course of school work. This group—a minority in the school population—has not achieved satisfaction from its peer-group relationships, at least as defined this way. In this group smoking may be a compensatory form of behavior, symbolic of problems of emotional health that are more significant than the smoking itself, which is merely symptomatic. This factor accounts for about one-fourth of the smoking in the series.

3. We found that there was a higher proportion of smokers in the Catholic schools than in the public schools of Portland. Since Catholic parochial schools are reputed to have stricter discipline than most public schools, one possible hypothesis is that this high rate of smoking represents a rebellious reaction against restrictions. Unfortunately, we do not have the data to test this hypothesis.

However, a review of the parental attitudes toward smoking as reported by the students shows that roughly 10 percent of all high school smokers smoke despite parental prohibitions. More girls than boys do so, and there is somewhat more defiance of paternal than of maternal prohibitions.

Thus, the three broad factors involved in high school smoking can be considered as: (1) parental, family, or cultural; (2) peer-group or sociological; and (3) personal or psychological. These factors represent three different etiologies in the acquisition of the smoking habit. Is there any reason to believe that they would respond similarly to different approaches to presenting educational material on smoking? Is there any reason to believe that they would be equally amenable to change?

To measure the effect of the materials we calculated a "net recruitment rate"—the difference between the proportions of regular smokers at the beginning and at the end of the school year expressed as a percentage of the proportion of nonsmokers at the beginning of the year. For example, if 20 percent of a group were regular smokers at the beginning of the year and 28 percent by the end of the year, this increment of 8 percent among smokers expressed as a percentage of the 80 percent of nonsmokers at the beginning of the year gives a net recruitment rate of 8/80 or 10 percent—10 percent of the nonsmokers became smokers. While undoubtedly a few smokers became ex-smokers, this measure balances each ex-smoker against a new smoking recruit in calculating the net recruitment rate.

### *Effects of Educational Approaches*

The most effective approach we found to a reduction of smoking was the one called "remote."

Among boys in the control group the net recruitment rate was 13 percent. Among those who received materials taking the "remote" approach the recruitment rate was 7.7 percent, a reduction of about two-fifths from the rate among the controls. This change was statistically significant around the 1 percent level. The "both-sided" material was the only other approach that produced results close to statistical significance. Among the boys who received this the net recruitment rate was slightly over 9 percent as compared to the 13 percent rate among the control group boys.

The other three approaches all gave results hovering around 11 percent—a reduction in each case well within sampling variability. Yet it is worthy of note that in every group receiving material, whatever the approach, the recruitments to smoking were at a lower rate than in the group which received none of the materials.

Among the girls in the control group the recruitment rate was 6.4 percent. Here both the "remote" *and* the "contemporary" approaches produced sta-

tistically significant results of approximately equal degree, with net recruitment rates around 2 percent, or a reduction by over two-thirds from the rate among the controls. Again the "both-sided" materials approached statistical significance, with a recruitment rate of 3.4 percent. The "adult role-taking" approach had the same recruitment rate as the controls, in other words, no effect, and the "authoritative" approach resulted in a rate somewhat higher—7.5 percent—than the rate among the controls, although this difference was not statistically significant.

It is interesting to note that among girls parental prohibition of smoking results in more smoking than does strong parental disapproval. Smoking despite parental prohibitions represents a larger proportion of female smoking than of male smoking. And a highly authoritative approach pushes the recruitment rate of girls slightly beyond that of the controls. These findings will interest all men who are interested in feminine psychology.

### *The Remote Approach*

In summary, we found that the "remote" approach was most effective with both boys and girls. The "contemporary" approach was as effective with girls as the remote approach, but not with boys. The "both-sided" approach was fairly effective with both groups. At this point a review of all the material seemed imperative. What did the three pieces of material labeled "remote" have in common that distinguished them from the other material?

Essentially, they said: "You've heard a lot of arguments about smoking cigarettes, but we have something new to say. We have learned many facts that lead to the conclusion that the smoking of cigarettes can cause lung cancer. We had not known this. But now there isn't much doubt. Here is some of the evidence. . . . Think about it before you decide to smoke."

As such, the appeal is a logical one to the intelligence of our youth. I am happy to say that the young people responded. True, we have some who did not respond. So far the evidence is that this approach was most effective among those who smoked in emulation of their parents, and less so among those who smoked for the more emotionally tinged reasons of compensation or rebellion.

I have discussed these findings with a science writer, pointing out that one commonly considers that having long-term goals is a mark of maturity, having short-term goals a mark of immaturity. He suggested that what we had found was that "these kids talk like children, but behave like grownups." Perhaps when we study adults in relation to smoking we shall find that they "talk like grownups, but behave like kids!"

The extent of the response to the remote approach, namely the reduction of the 8-month net recruitment rate from 13 percent to 7.7 percent in the boys and from 6.4 percent to 2.1 percent in the girls may seem small. Yet, carried on cumulatively for a period of 4 years it would mean that about 20 percent of our high school students who would otherwise become regular smokers by graduation time would not do so.

A dividend to these studies on teenage smoking is a bit of understanding that may provide a powerful tool to the modification of adult smoking behavior. Quite apart from the effects of smoking on the health of adults, the fact that parental smoking is an important factor in teenage smoking poses to each parent the question: "Do I want my children to smoke?" and "Does the fact that I smoke influence my children to smoke?"

Cancer control depends not only on learning more about the causes of cancer, but, perhaps even as important, learning more about why people behave the way they do.

On this basis, what recommendations can we make?

### *Recommendations*

1. That new materials on smoking be prepared to tell the lung-cancer story. The contemporary effects of smoking are already well covered in health education textbooks.

2. That emphasis be placed on the fact that this is something new, something we now know that we did not know in the recent past.

3. That a touch of both-sidedness be added to flavor the pottage: the permissive recognition of the fact that smoking is a natural, normal piece of behavior, indulged in every day by perfectly nice people, who unfortunately began smoking cigarettes before the damage that could ensue was fully appreciated.

The American Cancer Society has already prepared a film strip with recorded narration along these lines, suitable for youth groups, and available from its local units or State divisions.

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[1] Horn, Daniel; Courts, Frederick A.; Taylor, Robert M.; Solomon, Erwin S.: Cigarette smoking among high school students. *American Journal of Public Health*, November 1959.

*A summary of the recommendations of the Advisory Council on Child Welfare Services . . .*

# A LOOK TO THE FUTURE IN CHILD WELFARE SERVICES

JOHN C. KIDNEIGH
*Chairman, Advisory Council on Child Welfare Services*

EARLY IN JANUARY the Secretary of Health, Education, and Welfare and the Congress were presented with copies of a report containing recommendations which may have far reaching effects on child welfare services throughout the country. This was the report of the Advisory Council on Child Welfare Services appointed by the Secretary of Health, Education, and Welfare early in 1959 in response to a direction from the Congress made at the time of the passage of the 1958 amendments to the Social Security Act. The Council was to advise the Secretary of Health, Education, and Welfare and the Congress about child welfare services. It was composed of 12 persons, including representatives of public, voluntary, civic, religious, and professional welfare organizations and of the public, including persons with special knowledge, experience, or qualifications with respect to child welfare services.

During the course of its deliberations the Council, with the staff assistance from the Children's Bureau, gathered information from all of the State public welfare agencies in the country and from national voluntary child welfare agencies.

Prior to 1958, grants from the Federal Government to State governments for child welfare services were to be expended in rural areas and other areas of special need. The 1958 amendments authorized the use of Federal money for child welfare services in urban areas on the same basis as in rural areas. One of the questions which the Congress was considering at the time of making these amendments was: "Will the extension into urban as well as rural areas affect deleteriously the local voluntary child welfare agencies in this country?"

Apparently there was fear in some quarters that the extension of coverage to urban areas would have a negative effect upon the programs or financial support of voluntary agencies, which are located mainly in urban areas. After careful assessment of the facts, the Council came to the conclusion that there is no evidence to support the contention that the use of Federal funds in urban areas either has negatively affected or will negatively affect the child welfare programs of voluntary agencies.

The Council also came to the conclusion that some basic changes in Federal law are indicated if the child welfare services in this country are to keep abreast of increasing need arising from increasing population and other factors. It is the purpose of this article to report briefly the recommendations made in the Council's report to the Secretary and the Congress; to indicate briefly some of the reasoning in reaching those recommendations; and to make a comment concerning implications for the future, should the Congress decide to enact the recommendations into law.

The Council's recommendations can be roughly classified in three categories:

1. Seven substantive recommendations requiring changes in law. These, if followed, would up-date child welfare services in this country and revise the Federal role in connection therewith.

2. Seven recommendations dealing with the 1958 amendments. All of these aim to improve the present Federal legislation under which child welfare services are administered, but some of them will not be necessary if the recommendations in the first category are accepted by the Congress and enacted into law.

3. One recommendation urging the Congress to expand the personnel and financial resources of the Children's Bureau so that it can more adequately discharge its appropriate functions.

### *Substantive Recommendations*

The recommendations in the first category, representing the most important substantive suggestions which the Council offers to the Congress, are:

#### I. A NEW DEFINITION OF CHILD WELFARE SERVICES

Since 1935 the definition of child welfare services in the Social Security Act was imbedded in the provision for Federal financial participation in State efforts for "the protection and care of homeless, dependent and neglected children, and children in danger of becoming delinquent." The Council regarded this definition of child welfare services as inadequate. After having considered various definitions it recommended to the Congress the following as most nearly meeting present and future needs:

> Child welfare services are those social services that supplement, or substitute for, parental care and supervision for the purpose of: protecting and promoting the welfare of children and youth; preventing neglect, abuse and exploitation; helping overcome problems that result in dependency, neglect or delinquency; and, when needed, providing adequate care for children and youth away from their own homes, such care to be given in foster family homes, adoptive homes, child-caring institutions or other facilities.

This definition avoids labeling or categorizing children. It recognizes the need of every child for parental care, protection, and supervision, and emphasizes the need for services to achieve this for children. Its broadness provides greater latitude for the inclusion of services dealing with any social problems affecting the well-being of children. By including the words "other facilities" the definition does not limit the care of children outside their own homes to the type of facilities listed. Moreover, the phrase "helping overcome problems that result in dependency, neglect or delinquency" recognizes that programs of many State public welfare agencies include responsibility not just for the prevention of delinquency, but for the treatment of delinquent children as well.

#### ADVISORY COUNCIL ON CHILD WELFARE SERVICES

John C. Kidneigh, chairman; director, School of Social Work, University of Minnesota, and president, National Association of Social Workers.

William T. Coleman, attorney, Philadelphia.

Fred Delliquadri, at the time of appointment, director, Division of Children and Youth, Wisconsin Department of Public Welfare, now dean, New York School of Social Work, Columbia University.

Very Rev. Msgr. Raymond J. Gallagher, chairman, program committee, National Conference of Catholic Charities.

Maurice B. Hexter, executive vice president, Federation of Jewish Philanthropies, New York.

Margaret Hickey, public affairs editor, *Ladies' Home Journal.*

H. Harold Leavey, vice president and general counsel, California Western States Life Insurance Company, and president, Catholic Welfare Bureau of Sacramento.

Leonard W. Mayo, executive director, Association for the Aid of Crippled Children, New York.

Joseph H. Reid, executive director, Child Welfare League of America.

Thomas J. S. Waxter, director, Maryland State Department of Public Welfare.

Ellen B. Winston, commissioner, North Carolina Board of Public Welfare.

William G. Stratton, Governor of Illinois. (Unable to attend the meetings of the Council.)

The adoption of this new definition of child welfare services would mean that State child welfare agencies could receive Federal help in offering a broader range of services for children, including the treatment and control of juvenile delinquency. The effect would be a better coordination of public services for children at every level of Government, with a properly staffed public welfare agency in each State playing a major role in meeting more adequately the needs of children throughout its particular State.

#### II. FEDERAL PARTICIPATION IN TOTAL COST OF CHILD WELFARE SERVICES

Up to the present time Federal grants-in-aid to State agencies have been used to assist in "establishing, extending, and strengthening" child welfare services in the States. The primary emphasis, therefore, have been on the stimulating effort rather than on paying part of the total cost of the child welfare program. While the Council recognizes that Federal funds so granted to the States and their subdivisions have made it possible for the States to do more than

they otherwise could, it believes that this system of Federal-State cooperation is inadequate for meeting recognized needs, and it proposes a basic revision of the Federal role in this system of Federal-State cooperation. It therefore recommends that:

The Federal Government pay part of the total cost of public child welfare services of each State and other cooperating jurisdictions through Federal grants-in-aid on a variable matching basis, with provision for an open-end appropriation, and with continuing encouragement to establishing, extending, and strengthening such services. The statutory provision for an open-end appropriation should be formulated in such a way as to assure that there would be no decrease of a particular State's expenditure of State or local money for child welfare services as determined by the fiscal year 1960 or some other base year.

This recommendation proposes to change the Federal Government's role from that of being a grantor for projects which stimulate effort in the States to one of full partnership with the States in the basic support of child welfare programs throughout the country. This would bring the Federal Government into a role similar to the one it plays in its grant-in-aid program for public assistance. It would enable the States to develop, expand, and improve services to meet social problems of children and families, strengthen family life, and work toward the stability of the family and the community.

This recommendation is based on a recognition that child welfare services are an essential and a joint responsibility of the Federal Government and the States. It would greatly encourage the States to develop a comprehensive program involving total resources, public and voluntary. It would provide a basis for overall program standards, encourage the equalization of services to children between and within States, and enable the States as rapidly as possible to see that all necessary child welfare services were available and to expand these services to keep pace with the swelling child population, the complexity and tension of today's living, the mobility of our population, and the rise in juvenile problems.

This is, therefore, the most far-reaching recommendation made by the Council in its report. If accepted it would undoubtedly have a striking and salutary effect upon child welfare programs, both public and voluntary, throughout the country.

It is, however, the only recommendation which produced any dissent or qualification in the Council. One member, Monsignor Gallagher, qualified his assent to the recommendation with a written statement expressing the opinion that the growth of public welfare is due not only to "other agencies failing to meet normal increase of need," but also to the breakdown of the family within American society. He proposed that if the Federal Government is to finance extended coverage of child welfare services it (1) accept an obligation to find and reveal the effects of social trends on family life and hence on child welfare, and (2) encourage the purchase of child care on a case-by-case basis by public agencies from voluntary agencies and institutions as the primary means of extending public welfare services.

The dissent came from another member of the Council, Mr. Leavey, who expressed disapproval of Federal grants-in-aid for ongoing programs as a form of Federal domination of the States and especially of open-ended appropriations as unsound fiscal policy. "There is no showing that the several States cannot finance all of the public child welfare projects they choose," he maintained.

In its report the Council approved the principle of purchase of service from voluntary agencies and institutions on a case-by-case basis wherever needed. Thus public agencies under this recommendation would have Federal support in purchasing, among other necessities, foster care for children from voluntary agencies meeting acceptable standards—a practice which would tend simultaneously to raise child welfare standards in voluntary agencies and improve child welfare programs carried on under public auspices.

### III. CONDITIONS OF PLAN APPROVAL

Under present provisions of the Social Security Act, when Federal funds are granted to a State for child welfare services, the State is required to submit a plan, jointly developed by the State and Federal agency, for the use of such funds. The Council concluded that Federal legislation should include more specific requirements for the approval of State plans for child welfare services than this provision requires so that services will conform more fully to standards accepted in the child welfare field. It recommended that such plans:

(a) be developed jointly by the State agency and the Secretary of Health, Education, and Welfare; (b) provide for the administration by the State public welfare agency or the supervision of the administration of the plan by the State public welfare agency; (c) provide for such methods of administration, including maintenance of personnel standards on a merit basis, as are necessary for the proper and efficient operation of the plan; (d) provide that the State public welfare agency will make such reports in such form and containing such information as the Secretary may from time to time require and comply with such provisions as he may find necessary to assure the correctness and verification of such reports; (e) provide for progress in coverage and in moving toward a comprehensive child welfare program; and (f) provide for consultation with other public and voluntary agencies and citizens.

The several kinds of plan-approval standards included are already widely accepted in the field as essential to the improvement of services. The provision for consultation "with other public and voluntary agencies and citizens" helps to give, among other advantages, a better guarantee that each of the several States in formulating its State plan will take a comprehensive view of the needs of children in their States and of the resources available.

### IV. GRANTS FOR DEMONSTRATION AND RESEARCH PROJECTS IN CHILD WELFARE

Experience has shown that special projects to discover and develop new or improved methods or facilities or to evaluate them have proved to be effective ways of stimulating better services. Congress has recognized the importance of this principle in many fields of health and welfare. The Council believes that intensive study and experimentation are essential for progress in the child welfare field. It therefore recommended that:

**Federal legislation provide for grants to research organizations, institutions of higher learning, and public and voluntary social agencies for demonstration and research projects in child welfare.**

The enactment of this recommendation would give specific encouragement and incentive to experiments and research directed toward new or improved methods for child welfare programs as a whole. In addition it would encourage research into considerations of basic cause which should add to our body of knowledge and give direction for preventive programs.

### V. GRANTS FOR TRAINING OF PERSONNEL IN CHILD WELFARE

The shortage of people qualified to work in and administer the child welfare programs of this country is acute and will become more so. It is widely recognized that in order to improve or expand professional service in the health and welfare field attention must be paid to the training facilities which produce the qualified professional personnel. The Council estimated that at the present time 3,000 additional public child welfare workers possessing professional social work training are needed to provide minimum coverage for the Nation and that 4,300 more will be required by 1970. It therefore recommended that:

**Federal legislation provide grants for training personnel (a) to State departments of public welfare, which may be used for scholarships to individuals; (b) to accredited schools of social work, which may be used for scholarships to individuals and for expanding and improving training resources for the child welfare field and (c) to public and voluntary social agencies to conduct training projects in child welfare of regional or national significance.**

The expansion of educational facilities is essential to guarantee a constant stream of professionally educated personnel entering the child welfare field. Not only is there a great need for professional personnel, but also a need for houseparents, volunteers, and others in positions not requiring professional training. If this recommendation is enacted into law by the Congress, substantial progress can be made in recruiting and training all types of child welfare personnel. This should result in a greater supply of qualified people for both public and voluntary child welfare agencies.

### VI. ADVISORY COUNCIL ON CHILD WELFARE SERVICES

One of the basic factors in the continued maintenance and development of child welfare services in this country is the work done by interested citizens in telling the public about the needs of children so that immediate and long-range goals may be better understood. In connection with nearly every proposal it discussed the Council recognized the need for a national group to give articulate support to the Children's Bureau, as the arm of the Federal Government concerned with children. It therefore recommended:

**Federal legislation to provide for the creation of an Advisory Council on Child Welfare Services to the Children's Bureau, with its structure, function and membership authorized by the Congress; the Council to study and report to the Secretary on philosophy, broad policies and program concerning social services to children and youth, and to interpret to the public the social welfare needs of children.**

Such a Council would not be involved in administrative responsibilities but would function primarily in the development of citizen interest and understanding of the changing needs and problems in child welfare services.

### VII. PROVISION OF MEANS TO EXAMINE BASIC CAUSES OF FAMILY DISRUPTION

In much of its discussion the Council was concerned with making recommendations that would improve the services needed to deal with the problems of children. But it was also aware of the importance of a better understanding of the causes of children's problems. It found a need for a study looking toward an identification and understanding of the

causes of family disruption, the source of many of the problems with which child welfare services must deal. A deep conviction that the preventive aspects of child welfare must receive attention and support led the Council to formulate a recommendation which would authorize the Federal Government to play a significant role in child welfare research. This is:

(a) That the Secretary of Health, Education, and Welfare through the use of the Children's Bureau be charged to examine and look into the basic causes underlying those phenomena which result in problems to children and families, and (b) that Congress provide the necessary funds.

### *Regarding the 1958 Amendments*

The Council's seven recommendations, dealing primarily with the 1958 amendments to the Social Security Act, were made in answer to a specific request from Congress for recommendations and advice in connection with "the effectuation of the provisions of part 3, title 5 of the Social Security Act as amended by the Social Security Amendments of 1958." Some of these recommendations were technical in nature. The seven may be summarized as follows:

1. That the amendment extending the use of Federal funds to urban as well as predominantly rural areas be retained.

2. That the formula for apportionment of funds for child welfare services as previously enacted be retained. The Council reports, however, that the present formula can have little meaning in actually extending Federal support to urban areas unless there is a substantial increase in the Federal appropriation.

3. That the amount authorized for child welfare services as well as the actual appropriation be substantially increased. The present law authorizes an appropriation of $17,000,000 a year, but the Congress thus far has appropriated no more than $13,000,000 for any one year.

4. That if legislation is not passed to enable the Federal Government to participate in the total costs of child welfare services as recommended in the first category of recommendations (Recommendation II), a reexamination of the present matching requirements of the act be made with a view to appropriate legislative changes. The concept of "Federal share" referred to in the present law is inappropriate under the present provisions.

5. That the provisions of the present law for reallotment of unused funds should be continued with provision made for a greater use of administrative discretion.

6. That there be no change in the law concerning the return of runaway children.

7. That Guam should receive Federal funds for child welfare services in the same manner as the States.

### *The Children's Bureau*

The Council's recommendation concerning expansion of the Children's Bureau grew out of its shock in finding that the Bureau has been seriously handicapped in doing its job because of the lack of sufficient staff. In recommending that the Congress "provide the financial means to enable the Children's Bureau to carry out its functions and duties," it points out that the need for additional personnel will become even more critical if the Council's recommendations are adopted.

The range of service which the Children's Bureau provides is of fundamental importance if there is to be adequate child welfare service in this country. Despite its outstanding record, the Bureau has not been able to do as many things as fully as it should in developing standards, producing publications, administering grants-in-aid, providing consultation services, conducting research, strengthening family life, encouraging community planning and organization, and providing leadership which is essential in the light of the child welfare problems faced by this country.

In addition to its recommendations and the reasoning behind them, the Council's report contains important background information and factual material. It is being published by the Congress and will be made available to interested persons.

# THE PERVASIVE SHORTAGE OF PROFESSIONAL PERSONNEL

ALEX ROSEN
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IN A HARD-HITTING, frank and disturbing book, "Mental Health Manpower Trends,"[1] George W. Albee calls attention to the critical shortage of professional manpower in the mental health field. On the basis of diligent research, he asserts that we face a crippling manpower crisis in the future unless a drastic remedy is found soon. And he makes it clear that this crisis, involving as it does the various helping professionals, will affect not only the mental health field but the wider fields of public health and social service, and in fact the country at large through the loss of the productive capacity of those who need the various professional services to help them reach or maintain their full potential.

Does this predicted crisis, then, threaten our national security? Does it mean that we as a nation have become too absorbed with material comforts for our own welfare?

The study analyzes the complex factors responsible for the pervasive shortage of highly trained personnel in the various professions: the population explosion; the deficiencies in our educational system, especially as they relate to the stimulation of bright young people to enter the professions; the low salaries in the professions as compared to other occupations; the prevalent lack of respect for intellectual achievement in the country at large.

In the mental health field specifically, the psychiatrists, psychologists, psychiatric nurses and psychiatric social workers are in very short supply. Albee quotes the psychiatrist Daniel Blain in presenting a succinct picture of what this means:

> For lack of manpower, whole programs [in psychiatric services] lie in abeyance, clinical facilities are hopelessly overtaxed, and some are closed to new admissions. Waiting lists are static. Key positions, such as state commissionerships, superintendencies of mental hospitals, directorships of psychiatric clinics, and professorships, stand vacant for months and even years. Research, crying out to be done, awaits the scientist to carry it out. Teaching and supervision, the key ingredients of programs which will vastly expand our human resources, are only sparsely available.[2]

Albee maintains that the sources of our difficulties in supplying adequately prepared manpower is to be found in the climate of public opinion—an anti-intellectual, antieducational and antiprofessional trend in our social and cultural values. Referring to Plato, who observed that man cultivates that which he values, he points out that our increasing absorption with the accumulation of consumer goods has been accompanied by devaluation of intellectual pursuits. This he finds reflected in the low repute in which teaching is held and the lack of a ground swell of support for education in a time of crisis.

Citing the prevalence of poor academic salaries, Albee questions whether our society regards the college professor, who prepares our various professionals, as of any real importance. For instance, in 1953, the professors in large State universities, with incomes of $7,000, were earning less than railroad engineers; associate professors in these institutions, less than railroad firemen; assistant professors and intructors, 24 percent and 30 percent less than railroad conductors and switch tenders, respectively.

All the professions, including mental health, depend for their recruits on an increased number of able college graduates. Yet two-thirds of the qualified, intelligent American youth who have the capacity for college training do not go to college.[3] How long can we continue to squander our material and personnel resources so wastefully?

The contrast to the Soviet Union is startling. According to a story in *Time* magazine of November 30, 1959, the high jinks and casualness which prevail on so many American college campuses is rare at

Moscow University. The Russian students know that the avenue to success and material awards as well as to public esteem and prestige is through their educational system. The Russian university professor is well paid and has much higher status than his counterpart in the United States.

### *Use of Personnel*

The professional schools which prepare our psychologists, psychiatrists, psychiatric nurses, and social workers depend for their efficiency on the supply of well educated, qualified and motivated college graduates. The professional schools simply are not getting such students in great enough supply, and our wastefulness is compounding the shortage.

Those interested in work with children will be a little dismayed by the way some professional personnel are currently using their time. Albee observes that many professional workers, particularly psychiatrists and psychologists, spend a disproportionate amount of time with middle-aged well-paying neurotics rather than with disturbed children, who untreated will become the neurotics and psychotics of the future. At the same time, he points out, the boom in babies means increased need for more child psychiatrists, pediatric nurses, and school social workers.

The National Manpower Council has identified three ways of improving the supply of professional personnel: controls, exhortation, and the improvement of market incentives.[4] The Soviet Union is able to use controls in the education and placement of its professional personnel. This method is an anathema to a democratic society with its belief in freedom of choice for the individual. The challenge facing our society is to find a way of inducing large numbers of capable young people to enter the sciences and the professions voluntarily. In a free society appeals to patriotism and civic pride can be only partially effective in reaching such a goal. They must be accompanied by improved market incentives such as money, status, creative satisfaction, and professional security.

Albee suggests that there are five ways of solving the manpower problem in the mental health field: (1) to train more personnel; (2) to redistribute existing personnel; (3) to change patterns of patient care so as to achieve a better utilization of available professional manpower; (4) to apply new and different methods of treatment; and (5) to carry on research to discover ways of preventing and curing mental disorders.

These suggestions are in harmony with the report of the National Manpower Council, which has emphasized that one of the major solutions to the personnel shortage is the more effective use of existing personnel.[4]

A key principle of the manpower utilization is: an expert seldom works alone. A lawyer has his clerks, a doctor his technicians, an engineer his assistants. How much the expert accomplishes is partly determined by his own ability and partly by the number and skill of his assistants and how he uses them.

Thus, the suggestion has been made, and Albee reiterates it, that one way of alleviating the shortage in the mental health field is to prepare individuals with somewhat less training than the fully qualified professional person to assume limited and routine responsibilities, especially in hospitals and clinics. This radical suggestion has met with a mixed reception, for some observers feel it may dilute the quality of the profession. However, all of the professions are wrestling with the problem of trying to define different levels of responsibilities for which different levels of educational preparation might be required.

### *A Basic Need*

The mental health professions are new. Only recently in human history has society achieved enough material security to release persons from direct production to provide services to disturbed people. These new professions do not as yet have the status, prestige, and financial remuneration to attract enough able, educated young people.

Mental illness is one of the major sources of human incapacity and loss of manpower. It is disturbing not only from the point of view of a human being's happiness but also, in the context of our society's competition with the Soviet Union, as a threat to production of material goods, to the provision of needed social and health services, and thus to the national security. A complex, industrialized society cannot function without talented, able people in the sciences and the professions. No society can long endure that neglects its basic education, its teachers, its professors, and its professional personnel.

Unless there is a drastic breakthrough in the concern of the American people, the future looks dark indeed, not only for the mentally ill in our society but for all American citizens. To this reviewer it is the height of irony that a society which can navigate the heavens and conquer space does not have sufficiently strong motivation to provide the kind

of care for the mentally ill, and those threatened with mental illness, commensurate with its great wealth and new scientific knowledge.

[1] Albee, George W.: Mental health manpower trends. Monograph series no. 3, Commission on Mental Illness and Health. Basic Books, New York, 1959.

[2] Blain, D.: Relief of shortages in mental health personnel. Speech to Midwestern State Governments Conference, Chicago, April 29, 1958.

[3] The President's Committee on Education Beyond the High School: Second report to the President, July 1957. U.S. Government Printing Office, Washington, D.C., 1957.

[4] National Manpower Council: Womanpower. Columbia University Press, New York, 1957.

# BOOK NOTES

ORIGINS OF CRIME; a new evaluation of the Cambridge-Somerville Youth Study. William McCord and Joan McCord, with Irving Kenneth Zola. Columbia University Press, New York. 1959. 219 pp. $6.

This book reports on a reexamination of information collected two decades ago on more than 500 boys, half of whom had received counseling treatment in a 7-year research-oriented project to prevent delinquency and half of whom did not.

Ten years after the study closed the authors searched court records to find which boys in each group had been convicted of delinquency or crime. They then analyzed factors in the boys' lives in relation to their conviction.

Agreeing with an earlier evaluation of the project by Edwin Powers and Helen Witmer ("An Experiment in the Prevention of Delinquency," Columbia University Press, New York, 1951), the authors found that the counseling given did not prevent delinquency or criminality—"Neither in number of crimes committed nor in number of boys who became criminal did the 253 treated boys differ significantly from the 253 untreated boys." They found, however, that the younger boys and the few who received intensive rather than occasional counseling succeeded better in escaping delinquency than the others.

Neither intelligence, physical condition, nor social factors such as the neighborhood seemed to be strongly related to delinquency, the authors found, but home atmosphere was. Extreme tension in a quarrelsome and neglecting home was associated more frequently with delinquency than was a broken home; boys from quarrelsome homes, with or without affection, turned to delinquency at a relatively early age. Few of the boys who turned out to be criminals came from cohesive homes. The most fundamental influence seemed to be the mother's personality.

LONGITUDINAL STUDIES OF CHILD PERSONALITY; abstracts with index. Alan A. Stone and Gloria Cochrane Onqué. Foreword by Milton J. E. Senn. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Mass. 1959. 314 pp. $5.

The nearly 300 studies described briefly in this collection are primarily concerned with social and emotional behavior in infants and children. Most of them were completed in the period between 1930 and 1955. Among the foci of their concern are breast feeding, enuresis, sense of self, affectionate behavior, maternal overprotection, emotional reactions of children and families to hospitalization and illness, vocational choices made by high school pupils, and delinquency. The abstracts are presented alphabetically by author's name.

MENTAL DEFICIENCY; the changing outlook. Ann M. Clarke and A. D. B. Clarke, editors. The Free Press, Glencoe, Ill. 1959. 543 pp. $10.

With contributions from seven authors, this book, first published in England in 1958, reviews the literature on psychological and social aspects of mental deficiency, especially the books and articles published during the past decade; explains relationships between theory and practice in helping the deficient; and suggests ways of solving practical problems in the field. Included are chapters on measurement of intelligence, the etiology of mental deficiency, individual differences in the mentally deficient, cerebral palsy, and adoption of children of mentally deficient parents.

CHILD WELFARE; principles and methods. Dorothy Zietz. John Wiley & Sons, New York. 1959. 384 pp. $5.50.

Addressed to college students, this textbook, written by an associate professor of social welfare, traces the origins of community services for children from the English poor laws through developments in the United States in the succeeding centuries, emphasizing the period from the passage of the Social Security Act to 1957.

UNDERSTANDING MENTALLY RETARDED CHILDREN. Harriet E. Blodgett and Grace J. Warfield. Foreword by Evelyn D. Deno. Appleton-Century-Crofts, New York. 1959. 156 pp. $1.35 (paper).

The authors, both staff members of the Sheltering Arms, a research-oriented school for the mentally retarded in Minneapolis, discuss the problems and characteristics of mentally retarded children in relation to possible content and techniques in programs for their education, training, and leisure time and for helping their parents learn how to handle them. Pointing out the differences in conditions causing mental retardation and their effects on children, the authors warn against "overorganization" with the reminder that "what is good for one child may not be good for another."

# DECLARATION OF THE RIGHTS OF THE CHILD

as approved unanimously by the 14th General Assembly
of the United Nations, November 20, 1959

WHEREAS the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights, and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

WHEREAS the United Nations has, in the Universal Declaration of Human Rights, proclaimed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

WHEREAS the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth,

WHEREAS the need for such special safeguards has been stated in the Geneva Declaration of the Rights of the Child of 1924, and recognized in the Universal Declaration of Human Rights and in the statutes of specialized agencies and international organizations concerned with the welfare of children,

WHEREAS mankind owes to the child the best it has to give,

NOW THEREFORE

*The General Assembly proclaims this Declaration of the Rights of the Child* to the end that he may have a happy childhood and enjoy for his own good and for the good of society the rights and freedoms herein set forth, and calls upon parents, upon men and women as individuals and upon voluntary organizations, local authorities and national governments to recognize and strive for the observance of these rights by legislative and other measures progressively taken in accordance with the following principles:

**I.** The child shall enjoy all the rights set forth in this Declaration. All children, without any exception whatsoever, shall be entitled to these rights, without distinction or discrimination on account of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of himself or of his family.

**II.** The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose the best interests of the child shall be the paramount consideration.

**III.** The child shall be entitled from his birth to a name and a nationality.

**IV.** The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end special care and protection shall be provided both to him and to his mother, including adequate prenatal and postnatal care. The child shall have the right to adequate nutrition, housing, recreation and medical services.

**V.** The child who is physically, mentally, or socially handicapped shall be given the special treatment, education and care required by his particular condition.

**VI.** The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care and under the responsibility of his parents, and in any case in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother. Society and the public authorities shall have the duty to extend particular care to children without a family and those without adequate means of support. Payment of state and other assistance towards the maintenance of children of large families is desirable.

**VII.** The child is entitled to receive education, which shall be free and compulsory at least in the elementary stages. He shall be given an education which will promote his general culture, and enable him on a basis of equal opportunity to develop his abilities, his individual judgment and his sense of moral and social responsibility, and to become a useful member of society.

The best interests of the child shall be the guiding principle of those responsible for his education and upbringing; that responsibility lies in the first place with his parents.

The child shall have full opportunity for play and recreation, which should be directed to the same purposes as education; society and the public authorities shall endeavour to promote the enjoyment of this right.

**VIII.** The child shall in all circumstances be among the first to receive protection and relief.

**IX.** The child shall be protected against all forms of neglect, cruelty and exploitation. He shall not be the subject of traffic in any form.

The child shall not be admitted to employment before an appropriate minimum age; he shall in no case be caused or permitted to engage in any occupation or employment which would prejudice his health or education or interfere with his physical, mental or moral development.

**X.** The child shall be protected from practices which may foster racial, religious and any other form of discrimination. He shall be brought up in a spirit of understanding, tolerance, friendship among peoples, peace and universal brotherhood and in full consciousness that his energy and talents should be devoted to the service of his fellowmen.

# HERE AND THERE

## *Council's Report on Public Assistance*

"A hungry, ill-clothed child is as hungry and ill-clothed if he lives in an unbroken home as if he were orphaned or illegitimate." On that premise the Advisory Council on Public Assistance, appointed by the Secretary of Health, Education, and Welfare early in 1959 at the direction of the 85th Congress, has recommended that the Social Security Act's provisions for aid to dependent children be broadened to include children in need whether or not their homes have been broken by the death, absence, or incapacity of a parent. "The primary criterion for financial assistance to a needy child should be need," observed the Council in a report submitted to the Secretary and the Congress on January 4, 1960.

The recommendation is one of 20 made as a result of a year of study, in accordance with the Congress' direction that a Council be established to review the status of the public assistance programs carried out by the States under the Social Security Act in relation to factors bearing on the amount and proportion of the Federal-State shares in the program. While most of the Council's recommendations deal with Federal-State methods of sharing the financial burden of assisting persons in need, they do so with a focus on finding ways of meeting unmet needs, improving assistance standards, and strengthening family life.

Uncounted numbers of financially needy families and individuals can get little or no help from public funds, the Council reported, partly because they do not come within the categories of the States' federally aided assistance programs—old-age assistance, aid to dependent children, aid to the blind, or aid to the permanently and totally disabled. For this reason the Council recommended that the Social Security Act be amended to make it possible to use Federal grants-in-aid to encourage the States to furnish financial assistance and other services to needy persons regardless of the cause of their need.

The Council further recommended that the States be given freedom of choice in determining whether: (a) to establish a single category for financially needy persons, eliminating the four categorical programs; (b) to continue those programs and add a new category of general assistance; (c) to retain one or more of the four categories of assistance, and consolidate the remaining groups of needy persons into a single general assistance category; or (d) to expand the existing federally aided programs to include additional needy persons.

Noting also that many financially needy persons are debarred from public aid by States which will not assist persons who have not lived in the State for a specified length of time, the Council recommended that Federal grants-in-aid for public assistance be available only for State programs imposing no residence requirements for eligibility.

The Council also recommended that the Federal Government take leadership in creating the understanding necessary to bring assistance payments to levels adequate for health and well-being, to stimulate the States to extend the scope and improve the quality of medical care for which assistance payments are made, and to encourage the States to see that "similar treatment is accorded to persons in similar circumstances, regardless of the particular form of public assistance involved." "Dependent children are the stepchildren of public assistance," the Council observed.

Maximum amounts of average assistance payments in which the Federal Government is allowed to participate for aid to dependent children should be raised to bear equitable relationship with the maximums allowable in the other categories of assistance, the Council recommended. It urged that any difference in Federal maximums for the categories be "reasonably related" to available knowledge about differences in living costs among the groups of people involved. Federal maximums for all the programs should be high enough, the Council maintained, "not to hamper" State efforts to provide assistance at levels adequate for health and well-being and to meet rising living costs. It recommended that current maximums be raised.

In order to "improve administration, promote social rehabilitation, and help prevent dependency," the Council recommended that States increase the numbers and raise the qualifications of personnel administering public assistance, and that this be encouraged by increasing the Federal matching provisions for educational leave to cover the full cost. The Council also recommended that Federal funds be made available to graduate schools of social work for training persons "in such fields as strengthening family life and caring for the needs of the aged." In its report the Council referred to projects which have demonstrated that when persons receiving public assistance were helped with their personal problems—at least by workers carrying small caseloads—the workers' activities "paid off in terms of reducing assistance payments."

Pointing out that "people coming to the assistance agencies need more than money," the Council made a number of recommendations concerned with the strengthening of family life. One urged the Congress to appropriate funds, authorized under the 1956 amendments to the Social Security Act, for research and demonstration projects in this and other areas, including "the reduction and prevention of dependency." Another asked for the establishment of a National Institute, comparable to the National Institutes of Health, to conduct studies and demonstration projects in this direction. Still another urged the Federal Government to encourage States to involve public and voluntary agencies in undertaking such studies and developing coordinated programs for strengthening family life.

The Council also recommended moves to stimulate public interest and knowledge about the role of public welfare programs. "The more a community becomes part of a public welfare program, the better it will be," the report observes.

On the ground that improvements in social insurance would reduce the need for public assistance, the Council also recommended a number of measures that would extend coverage and increase benefits in the Old-Age, Sur-

vivors, and Disability Insurance program.

Other recommendations concerned fiscal and administrative operations of the public assistance program. The Council recommended that expenditures of the "open-end" method of appropriating funds be continued and that "for the present" the Federal share of total public assistance remain at the current level of 50 to 60 percent.

The Council went out of existence January 1, 1960, as required by the act establishing it. However, it recommended that the status of the public assistance programs be reviewed and reevaluated by an advisory committee at least once every 5 years and that the Social Security Act be amended to authorize establishment of such a council.

The Council was composed of 12 persons in addition to the chairman, the Commissioner of Social Security. They included representatives of employers, employees, persons concerned with the administration of financing of the program, other persons with special knowledge or experience, and the public. Three members submitted dissents to specific recommendations.

*—William L. Mitchell*
*Chairman, Advisory Council on Public Assistance*

## *Pan American Child Congress*

What are the countries in the Americas going to do about their expanding child populations—especially their abandoned, neglected, abused, and deprived children?

This was the pervasive question of the Eleventh Pan American Child Congress convened in Bogota, Colombia, in November 1959, and attended by about 200 representatives of 21 Republics in North, Central, and South America and the Caribbean islands.

"We are becoming countries with a greater proportion of children supported by a smaller proportion of employed adults." The statement was typical of many. Along with the effects of high birth rates, the Congress discussed the low levels of subsistence existing in many areas, the undermining of family ties by urbanization, the widespread inadequacy of family assistance and social service programs, and the low rate of elementary school attendance in some countries.

Many countries reported the movement of population from farms and mountains to cities, towns, and new industrial areas, and that this movement had weakened traditional family ties and ways of educating and caring for children. "The morals and strengths they had in the country seem to weaken when they come to the cities. . . ."

Twenty-six major resolutions were formulated by the Congress for consideration by the Inter-American Children's Institute of the Organization of American States. These included recommendations for better laws for protection of children; intensified study of causes and solutions relating to neglect and abandonment; more trained social workers to help families maintain their homes; improved school facilities and efforts to increase attendance; improved health measures for mothers and children; establishment of vital statistics and a census of living arrangements for children; and intercountry compacts for the care of minors who cross country borders or frontiers.

Delegates to the Congress represented many professions concerned with abandoned and dependent children in their respective countries. Social workers, lawyers, pediatricians, educators, laymen, administrators, and legislators were most heavily represented. Mrs. Katherine B. Oettinger, Chief of the Children's Bureau, was chairman of the United States delegation.

About one-half of the participating nations submitted reports on the current situations in regard to neglected children in their countries. The report of the United States discussed, health, education, welfare, and legal aspects of dependency and neglect, along with national and international cooperative relationships in behalf of dependent and neglected children. Two major facts were highlighted: (1) 3,750,000 children were receiving payments through the aid to dependent children, and old-age survivors insurance or veterans programs; and (2) in June 1958, 417,000 children were receiving services from public and voluntary child welfare agencies, of whom about 271,000 were living in foster family homes or institutions.

The first of these Pan American Congresses was convened in 1916 by the Inter-American Children's Institute. Over the years the congresses and the Institute have stimulated and promoted the development of child health, education, and welfare programs throughout the hemisphere.

In expressing his concern for abandoned children, the Congress's host, Dr. Alberto Lleras Camargo, president of the Republic of Colombia, commented on the present "period of great social and economic change . . . with its loosening of family ties," and added, "perhaps the child reared in a primitive culture was better off in some ways than the child reared in our advanced cultures."

*—Martin Gula*

## *White House Conference*

The Golden Anniversary White House Conference on Children and Youth recently released a chart book, the first of seven publications to be issued by the Conference before its Washington sessions take place, March 27 to April 2, 1960. Entitled "Children in a Changing World," the publication presents 70 charts, with accompanying text, emphasizing facts and trends in the social scene which affect the welfare of children. It was prepared by the Interdepartmental Committee on Children and Youth with technical staff assistance from the Children's Bureau.

The charts and text are presented in four sections. The first highlights the increase in numbers of births and size of families in recent decades, the concentration of the child population in a few States, the high proportion of mothers of young children in the labor force, the increase in school attendance, the growth of suburban living, and other social trends.

Another section shows among other problems that juvenile delinquency and births out of wedlock are increasing, that health, welfare, and educational personnel shortages are serious, that mortality rates are considerably higher for nonwhite than for white infants, and that accidents and cancer have become the most common causes of childhood deaths.

The third section shows, among signs of progress, that one-teacher schools are rapidly disappearing; that the number of States with desegregated schools is rising; that the majority of children being adopted by nonrelatives are placed by social agencies; that maternal and child health and crippled children's services are increasing.

In the last section the charts project the trends in child population, school

enrollment, youth employment, and occupational opportunities 15 to 20 years ahead, while the text comments on the implications of these trends for the families and children of the future.

The chart book is available from the White House Conference, 330 Independence Avenue, Washington 25, D.C. (Price $1.25.) It is part of the material being sent to all registered members of the Conference, the cost to be covered by the registration fee.

. . .

By the time this issue of CHILDREN comes out, the three volumes of background papers written for the Conference by selected authors will be off the press. Edited by Eli Ginzberg, chairman of the Conference's Committee on Studies, the volumes carry the overall title, "The Nation's Children."

Volume I, "The Family and Social Change," contains papers on the effects on American family life of population moves, demographic trends, cultural changes, general economic prosperity, urbanization, religious influences, and leisure time.

Volume II, "Development and Education," contains papers on the various factors in the development of personality—genetic, physiological, psychological, and societal.

Volume III, "Problems and Prospects," presents papers on such phenomena as juvenile delinquency and conflict between the generations and on the problems of specific groups—rural youth, Negro youth in the South, and Spanish speaking children. It also contains papers looking ahead to the future prospects and effects of voluntary and Government social services, the employment of women, and the social scene in general.

Orders for a paperback set of the volumes received by the White House Conference, 330 Independence Avenue before March 27 will be filled for $6.

This set is being sent to all registered members of the conference as part of the material being paid for by the registration fee. A post-Conference clothbound edition to be published by the Columbia University Press will sell for $13.50.

## *Birth Data*

A certificate of birth data for any child under 18 who was born outside the United States, whether or not he is a United States citizen, can now be obtained from the Immigration and Naturalization Service if the birth information is in the INS records. The certification form has space for the child's name, his date and place of birth, INS file number, and date and place of issuance of the certificate. This certificate may carry the child's legal name at the time the birth information was reported to INS or his legal name when the certification is requested. The certificate is not proof of United States citizenship.

Applications for the certification form (G-350) may be directed to any INS office. A fee of $3 is charged. If the child is a United States citizen born abroad, whose birth information was reported to a United States consular office at or near the place of birth, a copy of the report may be obtained from the Passport Office, Department of State, Washington 25, D.C.

## *Personnel*

A comprehensive survey of social welfare manpower in the United States, sponsored by the National Social Welfare Assembly, has been begun by the Department of Labor in cooperation with units of the Department of Health, Education, and Welfare. The study is expected to permit assessment of current needs for social welfare personnel and of the progress made in strengthening social welfare manpower resources in the decade since 1950, when a somewhat similar survey was made.

The survey is planned to obtain the following information on social-welfare, including recreation, workers employed by public and voluntary agencies: age, sex, and marital status; education and experience; type of program in which engaged; position held; salary; and working conditions, including fringe benefits.

The survey will have two parts:

1. A sample survey of all persons in all types of social-work and recreation functions in voluntary and public agencies, to be carried out by the Department of Labor's Bureau of Labor Statistics. In this part of the study questionnaires are being sent to all social-welfare, including recreation, workers in a nationwide sampling of counties.

2. An effort to secure complete coverage of public assistance, child welfare, and vocational rehabilitation workers, and medical and psychiatric social workers in Federally aided programs in all the States. This part of the study will be carried out by State agencies in cooperation with four units of the Department of Health, Education, and Welfare—the Children's Bureau, the Bureau of Public Assistance, the Public Health Service, and the Office of Vocational Rehabilitation.

## *For the Handicapped*

The Minnesota Department of Public Welfare has initiated a pilot project in four counties to make county welfare services more readily available to children attending crippled children's clinics. In each of these counties a welfare worker is assigned to serve as a resource person to the clinic. This worker interviews families and children regarded by the clinic's medical social worker as in need of any of the services offered by the county welfare department. In some instances, if the family has a number of social or emotional problems that interfere with the child's receiving maximum benefit from the clinic's health, medical, and rehabilitation services, the medical social worker arranges for a meeting between herself, the clinic nurse, the county welfare worker, and the parents to work out a joint plan for giving nursing and social casework services to the family.

As part of the project the county worker takes responsibility for explaining the programs, policies, and procedures of the county welfare department not only to the members of the families interviewed but also to other professional workers at the crippled children's clinic.

A set of common standards proposed for all types of specialized institutions for handicapped children has evolved in Iowa as the result of a year of work by a Standards Committee for Facilities Serving Physically, Mentally, and Emotionally Handicapped Children, a subcommittee of the State Board of Social Welfare's foster care committee. The subcommittee is composed of representatives of the professions of medicine, education, and social work, including educators, administrators, practitioners, and supporting laymen from the three fields.

In the beginning the subcommittee worked through three special committees concerned with mentally retarded,

physically handicapped, and emotionally disturbed children, respectively, with representatives of the State division of child welfare coordinating their work. As the separate standards were prepared in relation to each group, their similarities led to the development of a set of common standards which have been presented to institutional executives and board members in a series of meetings.

Among other provisions, the proposed standards include an upper age limit (70) for institutional personnel and a lower age limit (6) for the admission of young children, and stricter fire prevention regulations. Though the standards have not yet been officially adopted, as a result of these discussions the boards of a number of institutions are now engaged in an overall review of their programs, purposes, and goals.

## *Parent Education*

The University of Minnesota's Institute of Child Development and Welfare has made a series of 20 tape recordings entitled "Growing Up in the World Today" for use by parent study groups. Each 15-minute recording discusses a specific aspect of child rearing and is accompanied by a study guide to help the group leader to plan and conduct discussion. The only charge to the user is for postage and the cost of a blank reel of tape. Titles in the series as well as complete information on obtaining the tapes are given in a leaflet, "Using Tape Recordings in Parent Education," which may be obtained by sending a self-addressed stamped envelope to the Parent Education Program, Institute of Child Development and Welfare, University of Minnesota, Minneapolis 14, Minn.

. . .

The cries of very young babies from different causes have been recorded on tape by Dr. Samuel Karelitz and transferred to a phonograph record to help mothers and fathers recognize their babies' needs. The recording, for use in parent education groups, was made as part of a research study being carried out by Dr. Karelitz and others, in which vocal expressions of newborn and older babies are obtained at regular intervals from normal babies and from those with various abnormalities such as Mongolism, thyroid deficiency, and brain damage. In the course of the study the investigators will correlate patterns of vocalization with tests of behavioral development and later with tests of intelligence.

## *Juvenile Delinquency*

The Ford Foundation recently granted $1,095,000 to the National Probation and Parole Association to continue its program for citizen action toward prevention and treatment of juvenile delinquency and adult crime. The program was begun as a 5-year project in 1955 with a $600,000 grant from the Foundation. (See CHILDREN, January-February 1955, page 35.) Up to now it has helped in the establishment and support in 8 States of statewide citizens' committees or councils which work with judges, bar associations, correctional administrators, and professional workers from the various disciplines in the correctional field in order to: (1) find out how the State deals with the offender from first contact to disposition and treatment; (2) recommend improvements, assigning each recommendation a priority; (3) inform the public of its findings; and (4) stimulate individuals and groups—public and voluntary—to work for the recommended improvements.

Among the goals toward which such committees have worked with eventual success have been: a legislative appropriation for operation of a parole system in a State previously without parole officers; the doubling of a State's probation staff; a project to demonstrate the effectiveness of model court and probation services; a State merit system for correctional personnel; a plan for a model statewide correctional and juvenile court system; the provision of State funds to strengthen local court and community services for delinquency prevention; the development of training institutes for judges.

The new grant will enable the NPPA to extend the program to additional States where citizen-action programs have been requested.

. . .

Another Ford Foundation grant recently made to the NPPA, of $7,700, will support a study of the effect on children and young people of motion-picture and television programs depicting violence and crime. The association is planning to call together about 15 specialists in psychiatry, psychology, education, juvenile court law, probation, and law enforcement to consider the subject in the light of American and European studies on the relation between violence in entertainment programs and the actions of the young.

Dr. Peter Lejins, professor of sociology, University of Maryland, is directing the project as special consultant to the NPPA.

. . .

Methods and procedures in probation work will be studied by college seniors in the New York area in a course given during the second semester of the 1959–60 college year by the Probation Department of the Kings County (Brooklyn) Court. Students from 13 colleges and universities, selected by the heads of their sociology departments, will attend. Besides 15 lectures the course will include demonstrations of practice, use of probation reports, experience in group therapy for offenders under supervision, research projects, and fieldwork training.

Areas to be studied include: the place of probation in administering justice, the relation of courts to social welfare and other agencies, preparation of presentence reports, sentencing procedures, principles of supervising probationers, techniques used in handling youthful offenders on probation, and the significance of psychological and psychiatric material as an aid to judges in sentencing and in supervision.

## *For Youth*

The National Child Labor Committee recently formed a National Committee on Employment of Youth to develop public understanding of youth-employment problems, to encourage services that prepare young people for suitable and satisfying jobs, and to stimulate increased employment opportunities for young people under appropriate conditions. Upon request the new committee will help local communities to set up and coordinate programs to assist boys and girls to prepare for, obtain, and hold worthwhile jobs.

. . .

To bring the latest techniques and practical aids to Girl Scout leaders engaged in teaching music and dance, literature and drama, and arts and crafts, Girl Scouts of the U.S.A. is sending an arts caravan on a projected

3-year tour, to visit Scout councils in various parts of the country. Training sessions, which last 3 to 5 days, are held for persons working directly with girls and for those working primarily with adults. Three art educators, who staff the caravan, are traveling in a specially equipped station wagon carrying films and filmstrips, arts and crafts supplies, a sewing machine, books, records, and exhibit material. About 13,000 persons are expected to attend the sessions.

. . .

Most young people in a high income county spend time in passive recreation, but prefer more active sports, according to the findings of a survey among high school students planned and carried out by a group of high school seniors. Designed by the youth members of the Montgomery County (Md.) Youth Commission, with consultation from the Department of Health, Education, and Welfare, the survey was taken among groups of 10th, 11th, and 12th grade students in all six high schools of the county. While television, movies, music, and "drug store" (in that order) ranked first among the activities most frequently noted as participated in by the respondents, these forms of recreation were near the bottom among the "preferences" noted, with swimming, roller skating, tennis, and teen clubs taking top places.

Among other findings, the survey showed that the young people average about 13 hours a week on hobbies, that 40 percent work outside school hours (most of them for spending money), that most of them talk over their career and personal problems with their parents, that they are for the most part satisfied with their family relations. However, 18 percent of the down-county (Washington suburban) youth and 15 percent of the small-town and rural youth reported that they had no one to whom they felt free to turn with personal problems.

About 40 percent of the young people reported they were active in church-sponsored activities, but only 20 percent reported participation in community-sponsored activities. More than half the respondents said they expected to attend college.

While about half the young people reported that they seldom had physical checkups, 92 percent maintained that they nearly always felt well.

Findings of the poll have been published in a report entitled "The Needs of Youth, As Youth Sees Them."

# READERS' EXCHANGE

**BECK:** *Elaboration wanted*

Miss Beck's article performs a useful service in specifying some of the differential considerations on which a program of counseling with parents of retarded children can successfully be based. ["Counseling Parents of Retarded Children," by Helen L. Beck, CHILDREN, November–December 1959.]

One hopes the author will be able to follow this thoughtful article with a further discussion of some areas she has left unclear or not touched upon at all.

For example, she includes parents who are "inaccessible" to treatment among those for whom only brief services are recommended. But are these parents inaccessible to both group and individual treatment? Experience seems to indicate that parents "who have not accepted the diagnosis" may still accept and greatly benefit from group sessions. Such parents often initially resist involvement in a one-to-one counseling relationship with a caseworker. The latter becomes the recipient of some of the feelings aroused by team members who, in giving a definite diagnosis, have "made" the feared "worst" come true. While such a parent may be inaccessible to individual casework, the experience of being in a group of peers confronted by similar problems can be extremely helpful. In fact, one of Miss Beck's case examples illustrates this point.

I cannot quite agree with Miss Beck's statement that "parents have really to understand and accept the nature of their own problem . . . and be ready to identify with a larger group" before becoming effective members of parents' organizations. The type of participation in these groups and its meaning to individual parents obviously vary widely. However, my observations suggest that participation in such a group *in itself* often brings a parent to a grappling with, rather than a masking of, his problems in accepting a handicapped child. In fact, the mechanism that operates in such group participation may be similar to that observable in group counseling—a readiness to work through with one's peers problems one is not yet ready to share with a professional "outsider."

I wish Miss Beck would comment further about the parents who require only brief casework services because they have been able to come to terms with the traumatic problem of having had a mentally retarded child in an intellectually highly competitive culture. How have such parents been able to summon their personal strengths so quickly? What are the elements of family relationships, social supports, ideology, and values that sustain them? Knowing more about these factors might provide clues to more effective help to persons needing it.

*Alfred H. Katz*
*Head, Division of Social Welfare in Medicine, University of California School of Medicine, Los Angeles*

*Author's reply*

I am grateful to Mr. Katz for his thoughtful comments on my article.

Several correspondents have raised the question about the short-term contacts mentioned there. In answer to this, I would like to draw attention to the following considerations:

1. The paper is concerned with casework counseling, which in our setting is just one facet of a multiple contact approach. Thus the final interview may represent merely a summarization of a process of diagnosis, discussions, and considerations. It offers an opportunity to explore the need for further contact either immediately or at later stages, as needs arise. Since clinic contact continues, the caseworker may reenter contact at any point.

2. The parents who have known about their child's retardation long before

coming to our clinic may have worked out an adjustment to the problem by the time we see them. All they may need at this point is reassurance that they are doing an effective job.

3. As Mr. Katz indicates, there are factors of personality makeup, family and community support, cultural and religious background that play their role in facilitating or hampering adjustment. The importance of such factors and their specific impact on adjustment might be perhaps best illustrated through case material at some later date.

Mr. Katz's remarks related to group participation really warrant considerate, careful thought and elaboration of the many tangibles and intangibles that make groups helpful to troubled people. There are many studies available in this area, and there is still much material for future endeavors.

*Helen L. Beck*
*Chief Psychiatric Social Worker, Mental Retardation Unit, St. Christopher's Hospital for Children, Philadelphia*

*Steps to equilibrium*

I would like to reemphasize Miss Beck's point that an unhurried diagnostic process can be therapeutic. One often sees attitudes of very upset, anxious parents change as they come into contact with the various clinic personnel, and often the fact that each team member devotes time without the feeling of being rushed enables parents to emerge with renewed courage and ability to face their situation more realistically.

The most crucial and vulnerable period in providing services to the parents is at the point when interpretation of the findings of the study is to be made, as Miss Beck observes. It is important not only to discuss the findings with parents, but also to be able to provide some answer to their concerns about what they can do to help their child.

Miss Beck has pointed out that not all parents need or are able to use help; but being prepared to offer them whatever help they need can influence the way in which they accept what has been learned in the study.

I feel that more can be done than just to help parents with their immediate problems concerning their child, through helping them look at themselves in relation to their own situation, apart from their child. Parents should be discouraged from withdrawing from activities that will make their lives fuller and richer. One way in which some parents can be helped to regain their equilibrium and perspective is through identity with persons who face similar problems. Special parent groups set up by the clinic not only can be therapeutic, but also can serve as a means of preparing parents for membership in larger parent organizations such as the National Association for Retarded Children. I agree with Miss Beck that parents should be prepared for membership in such an organization in order to know what it is they wish to contribute to and gain.

*Mary L. Yates*
*Social Worker, Services for the Retarded Child, District of Columbia Health Department*

SANDUSKY: *A judge's view*

Annie Lee Sandusky's article, "Services to Neglected Children" [CHILDREN, January–February 1960], has compelled me to look back over my more than 20 years as a juvenile court judge with an historic eye that has seen many changes and refinements in community services to neglected children. Most noteworthy in this evolution has been the increased role taken by public welfare in assuming responsibility for services to children.

A few years ago in my own community our court staff was burdened with disproportionate numbers of so-called "protective" cases. Their primary function of meeting the needs of delinquent youth referred to juvenile court was being preempted by time-consuming neglect cases. In cooperative planning with the court and police officials, public welfare assumed responsibility for these neglected children, thus relieving the court of an administrative function which the other agency might handle more appropriately. As pointed out in Mrs. Sandusky's article, the city of Cleveland has reached a similar conclusion.

My own experience leads me to think that certain advantages to current programs for neglected children would follow from Mrs. Sandusky's suggestion that ". . . Mandatory legislation specifically defining the public welfare agency's responsibility for children who are neglected or abused is the best way to make sure that all such children will receive social services." A juvenile court judge is only too aware of the many children who fall "in between"—for whom the public welfare agency cannot now offer either the quantity or quality of service demanded by the particular situation. With statutory responsibility for a complete service to children, the public welfare department conceivably would be in a better position to develop the necessary auxiliary services such as emergency receiving homes for infants and shelter care for older children.

I would like also to emphasize that I do not believe there is an adequate substitute for the mature, professionally oriented caseworker in working with neglected children and their families. Too frequently yesterday's neglected children are the delinquents I am seeing in court today, and it is only too obvious that skilled casework assistance was not utilized at a time when it might have done the most good.

It is, however, encouraging to observe how the developments in private and public agencies' services to neglected children have brought these agencies into a cooperative team relationship with the juvenile court. We are beginning to talk the same language at both administrative and casework levels. At long last, the allied disciplines of law and social work are finding it possible to communicate "in behalf of the child." Clearly, social work has had to face up to certain legal realities as applied to the rights of children and their parents; at the same time, the legal profession has had to come to accept the basic role and competence of the social worker in child neglect matters.

*Donald E. Long*
*Judge, Circuit Court of Oregon, Portland.*

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## SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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ADMINISTRATION AND STAFF TRAINING IN INSTITUTIONS FOR JUVENILE DELINQUENTS. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 377, 1959. 47 pp. 20 cents.

Reports a workshop planned to throw new light on the task of professionalizing institutional services so that more effective service is rendered to the children and youth committed to institutions for juvenile delinquents. The workshop, attended by selected administrators of such institutions, was financed by a grant from the Ford Foundation.

CHILD WELFARE STATISTICS 1957 Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 51. 1959. 36 pp. Single copies available from the Bureau without charge.

Among other data included on State and public child welfare services are statistics on children's living arrangements, full-time and part-time personnel, vacant professional positions, expenditures for various purposes, educational leave, and caseworkers' salaries and caseloads. Figures on children receiving services through voluntary agencies are also included, as are data on adoptions.

HEALTH STATISTICS FROM THE U.S. NATIONAL HEALTH SURVEY; children and youth, selected health characteristics, United States, July 1957–June 1958. Department of Health, Education, and Welfare, Public Health Service. PHS Publication No. 584-C1. 1959. 13 pp. 35 cents.

A presentation through charts and text of information on the amount and kinds of illness, injury, and disability experienced by young people in various age groups under 25 in the year ended June 30, 1958, and on the extent to which they used the services of physicians, dentists, and hospitals. Respiratory conditions accounted for nearly two-thirds of all acute illnesses in each of the age groups.

FOOD; the yearbook of agriculture 1959. Department of Agriculture. 736 pp. $2.25.

This first of the Department of Agriculture's yearbooks since 1939 to be devoted to food and nutrition presents laymen with a scientific explanation of the components of food and discusses these in relation to the body's needs. Included, among others, are chapters on the nutrients, health and nutritional status of various segments of the population (including children in institutions), recommended food allowances, needs of various age groups and of expectant and nursing mothers, protection of food quality, developing food habits, and feeding programs.

EDUCATION OF THE SEVERELY RETARDED CHILD; a bibliographical review. Harold M. Williams and J. E. Wallace Wallin. Department of Health, Education, and Welfare, Office of Education. OOE Bulletin No. 12. 1959. 26 pp. 15 cents.

Part of the source material for a forthcoming publication of the Office of Education, this bibliography includes about 350 annotated references on the education of the "middle-range" retarded child (IQ from about 30 to 50).

CRIPPLED CHILDREN'S PROGRAM 1957. Sadie Saffian. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 54. 1959. 32 pp. Single copies available from the Bureau without charge.

Summarizes statistics on children receiving various types of services under the federally aided State crippled children's programs in 1957 and analyzes trends in the volume and type of services and the conditions for which treatment was given. Additional information is presented for children in regional heart centers, those with muscular dystrophy, and amputees.

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MAY • JUNE 1960

# Children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

## CHILDREN AND YOUTH IN A CHANGING WORLD

reporting on the Golden Anniversary White House Conference on Children and Youth

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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CHILDREN with potentials for living a creative life in freedom and dignity as pictured in the exhibit, "These Are Our Children," at the Golden Anniversary White House Conference on Children and Youth. (See pages 100 and 101.)

The Conference, sixth of the decennial White House Conferences on Children to be called since 1909, met in Washington March 27 to April 2, and is the subject of the major portion of this issue.

A former newspaperwoman, Dorothea Andrews has been with the Children's Bureau since 1951, except for a year devoted to free-lance writing. In 1950 she covered the Midcentury White House Conference on Children and Youth for the Washington Post, where for 10 years she specialized in reporting on local welfare problems. Recently she prepared the report "What Price Dependency?" for the District of Columbia Health and Welfare Council. (See page 120.) A graduate of High Point College in North Carolina, she began her career with the Washington News Service.

At present a sophomore at Depauw University, majoring in political science, Susanna Matthews has been a member of the President's National Committee for the 1960 White House Conference on Children and Youth since its formation in the fall of 1958. A member of the Michigan Youth Advisory Council and one-time member of the Michigan Youth Commission, she attended the Fourth Joint Conference on Children and Youth in Chicago in 1958, at which representatives of State youth commissions, national organizations, and the Federal Government discussed White House Conference plans. Planning to be a high school teacher when she finishes college, Miss Matthews will spend her junior year in France.

Dr. Edward D. Greenwood, vice-chairman of the 1960 White House Conference on Children and Youth, is coordinator of training in child psychiatry for the Menninger School of Psychiatry, Topeka. A member of the executive committee of the Kansas Governor's Advisory Committee for Children and Youth, he is a board member of the National Council of State Committees for Children and Youth. He is also a member of the boards of the President's Conference on Youth Fitness and of the American Orthopsychiatric Association and is president of the American Association for Residential Centers.

A social economist, Dr. Eveline M. Burns has been a professor at the New York School of Social Work since 1946. Her major concern has been the development of the doctoral program. Dr. Burns is a member of the Federal Advisory Council on Employment Security and acts as an adviser to numerous public and private welfare agencies. She was president of the National Conference on Social Welfare in 1959 and has been vice president of the American Economic Association. She is the author of "Social Security and Public Policy" and several other books.

## ◀ *the authors*

# IMPRESSIONS OF THE WHITE HOUSE CONFERENCE

*A nonofficial personal report of the Golden Anniversary White House Conference on Children and Youth, based on personal observations at the Conference sessions, conversations with participants, reading of speeches, abstracts, and press releases, and notes from colleagues* and other friends.*

KATHRYN CLOSE

"I HAVE an unshakable faith in the overwhelming majority of fine, earnest, high-spirited youngsters who comprise this rising generation of Americans."

So spoke the President of the United States on the evening of March 27, 1960, to the gathering of 11,000 persons assembled for the opening of the Golden Anniversary White House Conference on Children and Youth. Of those attending, some 7,600—including about 1,400 youths of high school and college age and 500 foreign visitors—were official delegates to the Conference. They spent the following 5 days in groups of various sizes, scattered throughout the hotels and public buildings of Washington, considering the state of affairs among children and youth across the Nation and making recommendations for improvement. Their stated purpose: "to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity." The result at week's end: over 1,000 specific recommendations directed to almost every conceivable type of organization and individual having a bearing on the lives of young people—the President, the Congress, Federal agencies, State and local governments, specific industries, the various helping professions, social and health agencies, churches, schools, community planners, police, courts, housing officials, adults in general, parents, "the family," and young people themselves.

The conferees had come from all 50 States and the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and Samoa, and from 73 foreign countries. They included clergymen, industrialists, union leaders, soldiers, sailors, farmers, social workers, nurses, educators, doctors, lawyers, Indian chiefs, Congressmen, policemen, judges, writers, broadcasters, practitioners of a variety of other vocations, housewives, and students. In short, this was a citizen's conference. The conferees' only common denominator, as Mrs. Rollin Brown, chairman of the President's National Committee, pointed out at the opening session, was their concern for the young.

The participants had shown concern for children and youth, as had many thousands of other adults and young people across the land, in their preparatory work for the Conference back in their home communities through local or State committees or through the national organizations with which they were affiliated.[1] They brought to the Conference not only the results of their own inquiries, but information gained through their perusal of the eight volumes of material on children and youth prepared for the Conference, two of the volumes based on their own pre-Conference efforts and the others prepared by experts of various kinds. (See page 118.) That these materials, though still almost "hot off the press," had already been widely read became clear in workgroup after workgroup, where participants would refer to one of the background or technical papers or a chart to make a point.

This was the largest Washington gathering of the six White House Conferences on Children called by Presidents of the United States since 1909.[2] It was largest in numbers of delegates and program participants—850 speakers, meeting chairmen, leaders, and resource people—and in scope of concern.

For the first 3 full days of the Conference, each delegate began the day listening to speakers at one

*Sarah L. Doran, Ethel Hawkins, Leora Wells.

of 5 concurrent Theme Assemblies, devoted successively to the subjects: Appraising Ideals and Values in the Changing World of Children and Youth; Assessing the Impact of Change on Children and Youth; and Adapting to Change and Innovation—the Effects on Children and Youth of Science, Technology, Population Pressures, and World Events. Following the Theme Assemblies came 18 concurrently held Forums, each with a different general topic: 9 concerned with various aspects of The World Around the Young—environment, mobility, support, nurture, opportunity, free time, mass communications, human resources, and beliefs; and 9 with various aspects of The Young in the World—moving toward maturity, from birth to puberty; moving toward maturity, from puberty to young adulthood; as learners and thinkers; as doers; as citizens; with mental handicaps, with physical handicaps, in conflicts, and with social handicaps.

After hearing speeches at his assigned Forum each conferee spent the first three afternoons of the week in one of 210 small workgroups, hammering out recommendations on one aspect of his Forum's topic—ranging in specificity from "the significance of a personal faith for children and youth" to "identification and treatment of the mentally retarded"—for presentation to the Forum on Thursday for a vote. Thus each recommendation submitted by the workgroup, after duplicates were weeded out by topic teams composed of representatives from workgroups of the same topic, were accepted or rejected through a vote of the 400 or so people in a Forum, but none were voted on by the Conference as a whole. The closing session on Friday, with the 7,600 participants assembled at the National Guard Armory, was devoted to summary, appreciations, and ceremony.

A group of Indian children from the Navaho reservation entertaining the conference participants at the Americana Ball. The ball was one of the affairs planned by the youth members of the President's National Committee.

Assignments to workgroups and Forums were made by an IBM machine "concerned" both with the participant's stated interest and the wider interest of keeping balance of representation in each group. Youth participants were a part of every group.

In spite of its bigness this Conference was notable in its degree and spread of individual participation. As the workgroups contained only about 30 people each, and were broken down each day into small buzz sessions of five or six people each, it was almost impossible for any delegate to be a listener only. "Almost" is used here advisedly for, in spite of the set structure and procedures, what happened in the workgroups was as various as human personalities. There were extra-permissive workgroup leaders who did little to provoke any discussion at all, leaders who always steered the discussion away from controversial issues, leaders who tried to guide the group into their own way of thinking, and leaders who exhibited unusual skill at helping people express their own ideas, holding down the unscheduled speechmakers, keeping the discussion to relevant issues, and giving everyone a chance to have his say.

There were youth who were aggressively conservative—"juvenile delinquents ought to be punished more severely"; youth who were aggressively progressive—to the point of using their free time away from the Conference to organize picket lines in support of the Southern student lunch counter "sit-ins"; youth who tried to say something but out of politeness or shyness couldn't break into adult-dominated discussions; youth who had to be prodded into saying anything at all. There were adult participants who talked too much, adults who did not talk at all; adults who both talked and listened.

Yet, with all the variety of the participants' background, personalities, and focuses of attention, out of their deliberations emerged some major threads of concern, showing up in session after session no matter what the assigned subject of discussion. The President anticipated some of these on the opening night when he spoke of the importance of their mission:

"First . . . you are working with the most precious resource of our Nation: a whole generation of

Americans who will someday make their country's policies and dispose its great power. . . .

"Second, this process of preparation for tomorrow's leadership grows increasingly difficult as rapid and momentous changes alter the look of tomorrow's world. . . .

". . . within this great context of change and accommodation there are certain imperishable values which must neither be changed nor abandoned. . . .

". . . For civilization is a matter of spirit; of conviction and belief; of self-reliance and acceptance of responsibility; of happiness in constructive work and service; of devotion to valued tradition. It is a religious faith; it is a shared attitude toward life and living. . . ."

The President singled out juvenile delinquency as a problem of worldwide concern to which the Conference must address itself. Pointing out that its causes are "multiple," he said that "multiple measures must be used to weed them out." Yet he warned against a tendency to generalize pessimistically about today's youth and asserted that a "happy family" was the surest way of preventing failures.

### *The Search for Integrity*

A similar accent on values prevailed throughout the Conference—inevitably no doubt because of the Conference theme (see page 87) and programing, but obviously also because of a deeply felt concern on the part of many speakers and delegates over what they regard as threats to personal and social integrity in American life today. This emerged not only in the speeches presented at the Theme Assemblies devoted to "Appraising Ideals and Values," but also in almost all other parts of the Conference, no matter what the assigned subject of consideration. Closely entwined were other obvious threads of prevalent concern—the desire to wipe the blight of racial discrimination from the American scene as quickly and as painlessly as possible and the desire to enhance the quality of education for all children.

There were those at the Conference who apparently did not share the President's faith in the youth of the Nation. They spoke of "softness," "boredom," and "lack of commitment." Two speakers quoted the lines from William Butler Yeats:

> "The best lack all conviction, while the worst
> Are full of passionate intensity."

The blame was put squarely on the adult world and the gap between precept and example. The culprits named were various—most frequently parents, often the school, sometimes the mass media of communication, sometimes public figures—but whoever the adults under fire the poison in American life was unequivocally identified as an accent on materialism.

Nobody, of course, suggested a return to the days when one-third of the Nation was "ill-fed, ill-housed, ill-clothed." On the contrary, considerable Conference attention—in oratory, discussions, and recommendations—was given to ways of bringing a greater proportion of the products of our material affluence to the still considerable proportion of our population living at bare- or sub-subsistence levels—a group estimated by one speaker to be 20 to 25 percent. Among the many suggestions which eventually became recommendations were increasing minimum wages and extending minimum wage laws to migrants and other uncovered workers, opening employment opportunities to members of minority groups, eliminating residence requirements for all health and welfare services, increasing unemployment benefits, broadening disability provisions of the social insurance program, and inquiring into the desirability of a system of family allowances.

Yet a widespread uneasiness about the possible toxic byproducts of affluence was clearly evident. Juvenile delinquency was reported as more prevalent in times of prosperity, and one cause suggested was the resentment of the socially and economically disadvantaged portions of the youthful population at their inability to share in the opportunities to get the things that today stand for success. "To cure delinquency," said one speaker, "we must cure ourselves."[3]

Another speaker saw our society as "30 seconds to midnight," its only hope lying in a rather immediate filling of "the vacuum at the value core"—both in the inner man and in the social structure.[4] Another, calling for "a defense in depth," maintained that "moral and spiritual values must never be dealt with in isolation from social issues."[5] He and many others called for full acceptance of minorities as a moral imperative.

### *Youth Responsibilities*

Of the 500 foreign visitors at the Conference only one was a program speaker. He urged the participants to consider how young people could be helped to develop "those technical and above all human qualities which can be used for the benefit of mankind"—how children could be helped "not only to receive and gain, but to give and share."[6] That

some attention was given this possibility was attested to by a recommendation from one workgroup for a youth technical assistance corps to work in other countries for the betterment of living conditions. A few other speakers also had their sights on the world at large. Said one: "Am I my brother's keeper? there is only one answer: 'Yes'—for if you are not, there is no future to mankind." [7]

The rapidity of social change and the complexity of the economy were frequently cited as causes of a sense of individual helplessness among both youth and adults. As one youth said in a workgroup: "I'm part of a generation that is faced with evidence daily that the H-bomb may drop tomorrow. We need something that tells us that life is worth something—has meaning." But an assembly speaker saw the complexity of life today as an opportunity for personal fulfillment through the acceptance of cooperative social responsibility. "It has been well said that today's hero like today's saint, must be an organization man." [8]

An educator contended that youth had "little of the crusading spirit." [9] But this and the many statements about youth's lack of conviction seemed to be belied by the actions of many of the young participants at the Conference. Groups of young people held caucuses throughout the week to plan strategy for "getting things done." They served notice of their intention to rally support for strong Conference recommendations endorsing racial desegregation in all phases of American life. One youthful chairman of a Theme Assembly announced at the close of the session that the Southern students protesting lunch-counter discrimination "will not stand alone." [10] Many of the scores of antidiscrimination recommendations passed in the Forums were originally introduced by young people in workgroups.

The young people, of course, were not unanimous in their points of view. While only isolated protests against desegregation as an eventual goal were heard in any part of the Conference, an effort to keep the antidiscrimination recommendations from being specific was led by a group of youth from Northern States who were circulating a petition that the Conference confine itself to endorsing "human rights." At the Youth Evaluation meeting on Thursday, where Danny Kaye was moderator, some parliamentary confusion complicated a battle over whether the words "in due time" should be substituted for the words "by 1970" in a recommendation calling for "substantial completion of school desegregation." However, the suggested substitution was eventually soundly defeated. This resolution, which was one in a list of "youth priorities" presented to the Conference (see pages 96–102) also called for the provision of equal access to housing for all individuals and elimination of discrimination in employment practices, and affirmed "the right of nonviolent resistance against all forms of social injustice."

### *Juvenile Delinquency*

Though concern for juvenile delinquency had its own setting in a Forum called "The Young in Conflict" and in 12 workgroups, opinions on what or who is to blame for its rise and on what to do about it came from almost all parts of the Conference. The expressions of the experts backed up the President's statement that it arises from many factors and that, therefore, many measures are needed to combat it. But the "experts" seemed divided on whether social or individual psychological factors bore most weight in its causation, as well as on the priorities in efforts to combat it. One speaker, a sociologist, called delinquency "the dark underside" of a general societal advance, caused by social dislocations and educational pressures and predicted that the increase in its incidence would not long continue. [11]

Other diverging points of view emerged in discussions of efforts to identify potential delinquents early. Two workgroups produced recommendations urging greater efforts to find children in early life who are "prone" to delinquency; but one of these groups put the emphasis on the development of predictive devices and the other on identification through symptoms of emotional distress and behavior. The latter urged that such "labels" as "delinquency prone" and "in danger of becoming delinquent" not be applied to children and youth merely on the basis of prediction scales "prior to antisocial conduct on the part of the child." A workgroup focusing on emotional disturbance in children also became concerned over the possible adverse effects of "labeling" and recommended that law enforcement agencies and courts not affix such labels as "delinquent" to children "prior to competent diagnosis of basic causes."

One Forum speaker, a social worker, pointed out that "far too many who are minor offenders when first they become known to us eventually become hardened criminals despite early identification." [12] What is needed, he said, is a planned community policy providing for case location, case screening, diagnosis, systematic provision of services, diversified resources, integration of services, and coordina-

tion of policy and program and of planning.

Another social worker called for a program which would reach out not only to the delinquent, but also to his family and community, "to reincorporate them into the social fabric." [13] Unless work with gangs is complemented by work with the family of the gang member, he said, "the youngster can be caught between the shifting values of the gang and the social values of the home."

Church, schools, recreation agencies, and above all "a good home life" were repeatedly cited throughout the Conference as important in the prevention of delinquency. The need for research into causes and effectiveness of treatment methods was frequently stressed as was the need for training of all kinds of treatment personnel. One recommendation urged the extension of Federal training to include in addition to psychiatrists "the other personnel concerned with prevention, early detection, and treatment of youth in conflict, namely, pediatricians, obstetricians, teachers, ministers, lawyers, welfare workers, probation officers, school social workers, and psychiatrists."

### *Education*

This emphasis on the need for stepped up training of all types of professional personnel emerged throughout the Conference no matter what type of service to children was under discussion. It was also the focus of the entire Forum, called "Human Resources," and its eight related workgroups, where the competition for the educated in this country was plainly regarded as one of the chief blocks to fulfilling promises to children made by this and previous White House Conferences. One speaker predicted: "Unless we devote a larger and better qualified share of the Nation's human resources to the educational, health, and welfare needs of the young, all our soaring hopes and glorious dreams, not only for our children and youth, but also for this country's future, will be frustrated." [14] Repeatedly emphasized was the dependence of the professions on the quality of elementary, high school, and college education—in other words, on the schools' preparation of young people with the ability and desire to go into the service professions.

Suggestions for improving the quality of education included increased financial support from all levels of government; relieving the schools of functions which "properly belong to the home or other agencies"; less emphasis on physical education and sports; employment of teachers on a 12-month basis; special projects for culturally deprived children; increased attention to the gifted as well as slow learners.

Over and over conferees called for expectations of "excellence" on the part of the schools and asked for greater stimulation of the gifted. But at least one educator maintained that such a goal need not conflict with equality of educational opportunities for all children, regardless of their intellectual potentialities. He maintained that persons who "accept the sophistry that equality inevitably means a commitment to mediocrity," overlook "the need for diversity of interest and varied intellectual power and special creativity." [15] Another educator maintained that to charge a school only with the intellectual development of its pupils is both "psychologically impossible and morally irresponsible." [16] He maintained that teachers' and pupils' personalities are bound to interact.

While there were those at the Conference who suggested that child labor laws ought to be reviewed in the light of the delinquency situation, others cited the steady dwindling in unskilled jobs to back the contention that every child in this country needs at least 12 years of schooling. A recommendation that the States require compulsory school attendance until the age of 16 was adopted. The consensus seemed to be that schools should make a greater ef-

### THEME OF THE CONFERENCE

The purpose of the 1960 White House Conference is to promote opportunities for children and youth, to realize their full potential for a creative life in freedom and dignity.

This effort will be based on:

(1) Study and understanding of the values and ideals of our society; the effect on the development of children and youth of the rapid changes in this country and the world; and how families, religion, government, community services—such as education, health, and welfare—peer groups, and the behavior of adults in their interactions with children and youth deter or enable individual fulfillment and constructive service to humanity.

(2) Examination of the degree of achievement of previous White House Conferences' goals and recommendations.

(3) Determination of the action that individuals, organizations, and all levels of government can take to implement Conference purposes.

Some of the Conference participants listening to a speaker in one of the Conference's 18 simultaneously held Forums.

fort to keep children interested in learning, through revision of program and the provision of more personal counseling and vocational guidance.

Views on curriculum content were various and conflicting, with advocates of sharper attention to vocational training, to science and the humanities, to preparation for family life. A 19-year-old college sophomore said that the average student today "tests everything with the question, 'How can I use what I am learning now when I am out of school?' " [17]

But a theologian took issue with those who regard learning as a means to an end—whether preparation for life or strengthening of national security. Maintaining that "learning *is* life," he called "the modest standards" of contemporary education "unfair to the potentialities of man." [18] Said he: "We prepare the pupil for employment, for holding a job. We do not teach him how to be a person, how to resist conformity, how to grow inwardly, how to say no to his own self. We teach him how to adjust to the public; we do not teach him how to cultivate privacy." Today's major challenge, he said, is "to save man from inner oblivion."

But whether "self-realization" or "social effectiveness," the goal of education was repeatedly presented as a responsibility reaching far beyond the task of the schools. Young people learn "wherever they are," one speaker pointed out, "at home, on the playground, and in Sunday school . . . sprawled before the TV set, sitting in the movies, hanging around street corners, or gathered in Boy and Girl Scout troops . . . from comic books, paperbacks, newspapers, and magazines. . . ." But parents are primarily responsible, she said, for "the kinds of pupils the schools have to work with." [18]

TV, radio, motion pictures, advertising, the press came in for some heavy criticism for not living up to their educational potentials, for incessant portrayals of violence, and for presenting force or greater material possessions as heroic ways of gaining the upper hand.

Points of view differed as to whether these media could have any detrimental effects on a well-loved, well-reared child. A representative of a broadcasting company called for "a Manhattan project to determine the effects of TV on children"; [19] but a psychiatrist pointed to the difficulty of designing controlled experiments of this nature.[20]

Others spoke of the values of TV in widening children's horizons and of its uses as teaching aids. There were calls for more parental control over TV watching and some expressions of apprehension about the effects on the younger generation of too much passive recreation. Said one speaker: "TV cannot enter your home without your consent." [21]

### *Family Life*

Thus again, as constantly throughout the Conference, the question reverted to the quality of parenthood and of family life. Mothers were called "irresponsible" for going to work outside the home. Fathers were blamed for not spending enough time with their children—or, conversely, for taking over the mother's role. Parents in general were accused of substituting a "phony togetherness" for depth of relationship. The young people were especially hard on parents, accusing them of not setting good examples, of not being firm, of not allowing enough freedom of choice.

But parents also had their defenders. A sociologist, for example, denied the existence of a moral decline and said that there is more dedication in the adult world today than ever before to "bringing into the world and bringing up the younger generation," [11] even though American women are fitting this in with other concerns which are giving them "richer, fuller lives." And a young college student said: "There is a 'me' who I want to be, and it looks like my father and mother."

A few voices, including some young ones, suggested that young people themselves had some responsibility for how they turned out. For example, in one workgroup when a youth representative blamed the "wildness" of a teenage neighbor on the

fact that his mother went out to work, a young German visitor said: "I think that by the time a person is a teenager he has a responsibility for the way he behaves and if he knows his mother has to work he ought to be ashamed for becoming wild." And a youth representative from the Deep South volunteered: "My mother has always had to work and when we were children, my father and mother told us why and what we had to do and we did it." And she added: "I think it is helping me to become what I hope to become."

A pediatrician pointed out that the development of responsibility begins early in life in a "reciprocal trust" between parent and child.[22] But a psychiatrist said that the interrelationship of the components of adulthood developed in early childhood "is not finally established until the latter part of adolescence."[23] Guidance agencies, she suggested, should help parents "to understand, tolerate, and remain available" to adolescents going through the "crisis" of sexual development.

A social worker, on the other hand, said that for many youth in disorganized neighborhoods, family conditioning has been completed "for better or for worse" as early as their 14th year. "What these half-grown youngsters now need, he asserted, "is the exertion of a general community influence on the environment round them."[24]

Calls for strengthening parental adequacy suggested a host of approaches. They included the elimination of such social ills as discrimination against minorities, unemployment in depressed areas; poor housing; educational programs such as family-life courses for school children and parent-education classes for adults; the provision of individualized services to parents with special difficulties—parents of mentally or physically handicapped children, parents in one-parent families, and parents too immature in their development to be able to function adequately. Recommendations were made that casework be provided in all public assistance programs and that aid be available to needy but intact families, so that financially distressed fathers will not be tempted to leave home to help their families become eligible for aid to dependent children.

Unmarried mothers of several children usually come from deprived backgrounds and have known punishment all their lives, a social worker pointed out.[25] They need interest and protective authority to keep them out of trouble, she maintained, not more punishment.

"We are guilty of community neglect," said another social worker, when we do not provide the services to help neglectful parents assume responsibility for their children.[26] He said that every community should have a coordinated program of: (1) services for children and their parents living in their own homes—casework counseling, homemaker services, day care services, school social services; (2) services for children who cannot be with their parents—foster family care, institutional care, emergency shelter care; adoptive services; (3) corrective services for children in conflict with the law.

A young man in a workgroup said he knew about "community neglect," because he lived in a housing project: "The agencies seem to move like satellites around the project without ever touching the needs of the people there. But they don't seem to know this."

### *Child Health*

The normal processes of child development received considerable attention at the Conference (see pages 110–116) as did the kinds of health services that can help prevent impairment of those processes. Periodic and continuing medical care should be provided for all children, one workgroup concluded, and in its discussions there emerged considerable concern over the quality of care. In a Forum speech a professor of public health referred to "our inability to provide adequate health services to certain groups of children"—those who depend on clinics for well child care.[27] Pointing out that 15 percent of infants but only 4 percent of preschool children visit these clinics, he found an indication of why they were considered not "worth the effort of coming" in a study which showed that 34 physicians working in such conferences spent an average of 4 minutes with each child.

This physician and others expressed concern over the rise in the infant mortality rate and the great discrepancies in rates among geographical areas and population groups, which be linked with lack of prenatal care. This concern was carried into at least one workgroup which recommended that a forceful attack be made to lower infant mortality and morbidity rates among American Indians and other minority groups.

New or increasing dangers to public health were also brought to attention—air pollution, water pollution, radiological hazards. Pointing out that "the genetic hazards of radiation pose an ominous threat to the health of the living and unborn generations," a State health officer found it deplorable that only

a few States have launched full-scale radiological health programs.[28]

A large portion of the attention to health was riveted on children suffering from handicaps—mental, physical, or emotional. The importance of emotional factors and interpersonal relationships in assisting or impeding treatment and rehabilitation of persons with any type of handicapped condition was especially stressed.

Considerable concern emerged over the growing numbers of children with congenital malformations, and in one workgroup a suggestion for providing eugenic counseling as a possible deterrent was made. This was, however, turned down as a recommendation on the ground that not enough is as yet known about this field.

In another workgroup there was some collision of opinions over whether mentally retarded children should attend special or regular clinics, but the group eventually decided that in view of the chronic nature of mental retardation and the past tendency to neglect these children special clinics are needed, at least now.

Over and over when discussion of the handicapped arose the need to integrate the various types of services throughout the community and to individuals throughout their lives was emphasized as was the importance of providing handicapped children with the basic health services that all children need.

### *Looking Back and Ahead*

A look back to 1950[29] reveals both sameness and difference in the concerns that were bothering White House Conference delegates then and in 1960. Certainly not all the pledges to children made by the 1950 delegates had been fulfilled in the ensuing decade. (See pages 105–109.)

Many of the hotly debated issues of the memorable all-day voting session of the Midcentury Conference were still subjects of controversy in 1960. The outcomes of two of these—releasing children from public schools during school hours to attend religious classes, and making birth control information available to those who want it—were the reverse of what they were a decade ago, the advocates of each winning recommendations as they did not in 1950. As far as this reporter could find out, there was no controversy in 1960 over nursery school classes in the public schools as there had been a decade ago. On the other hand, some problems receiving only moderate attention in 1950 had been swollen into problems of deep concern by the ensuing course of events—juvenile delinquency; the quality of TV programs; dislocations in family life caused by population movements from north to south, from country to city, from city to suburbia or to a new phenomenon, or at least one with a new name, "exurbia."

Perhaps the problem over which concern had been most notably broadened and deepened by the sweep of historical events was racial desegregation. At the 1950 Conference one of the most bitterly fought battles occurred over a repeatedly defeated attempt by youth delegates to get through a recommendation that no similar conference ever again be held in the Nation's Capital so long as its hotel and eating facilities were barred to the Negro participants. In 1960 this battle was no longer necessary since the 10 intervening years had brought striking changes to the city of Washington, and the hotels and restaurants were generally open to everyone.

In 1950 a recommendation endorsing President Truman's civil rights program was hardly won. But in 1960 the temper of the Conference for eliminating racial discrimination from American life (North and South) met with little opposition and resulted in scores of specific recommendations concerned with schools, housing, employment, and other opportunities.

Anything involving 7,600 freely talking people is bound to provoke some criticisms. Some professional persons reported feeling frustrated in workgroups where the IBM homogenization of participants sometimes meant no common level of understanding of the subject under discussion. Some young persons said they could not communicate with adults, and some adults said the reverse. But an abundance of communication obviously took place to produce the 1,600 recommendations that poured from the workgroups. One critic predicted that the Conference's size and diffuseness of focus would prevent results "proportionate to the investment and sacrificial effort of so many people."[30] He and others talked of "too much talk." However, the chairman of the President's National Committee pointed out at the closing meeting that "talk is preliminary to action."

Already a structure and procedures are being worked out for helping States to stimulate the kind of widespread participation in followup that went into preparing for the Conference. (See pages 102–104.) Since each participating State and national organization has already done some self-study in preparation for the Conference, their reports may be regarded at least as preliminary maps for pro-

ceeding. But some States will undoubtedly do some renewed reconnaissance and remapping in the light of the Conference's recommendations. (See page 92.)

In the closing address of the Conference, Arthur S. Flemming, Secretary of Health, Education, and Welfare, commended the participants for taking a strong stand against discrimination based on race, color, or creed; for calling attention to some vital needs in the fields of education, service to the mentally and physically handicapped, control of juvenile delinquency, and public assistance; for pointing to the serious nature of manpower shortages in the service fields and to their need for research; and for underlining the importance of a personal religious faith.

Agreeing that greater financial support is needed for education, the Secretary said he believed that the "time has come to obtain agreement on what should be our investment in education as a Nation" and as to "what constitutes a fair share of responsibility" for meeting this on the part of government "at all levels" and private contributors. He also said that the Federal Government must become a "more effective partner" in determining the causes of juvenile delinquency and demonstrating ways of dealing with it.

The Secretary urged the delegates to go back to their communities determined to demonstrate "that we do believe that man has an obligation to help his neighbor realize his highest potential."

What will come of it all?

Participants are not sure. But many of them no doubt feel somewhat the way one youth participant was feeling when a newspaper reporter[31] asked him "What good is it going to do?" Said the boy:

"I will tell you this. I came here interested in my particular subject . . . I think I'd have to say that I probably wasn't as tolerant or understanding as I am now . . . I think it's helped me, and, I hope, others. We all hope, I guess, that when we go back home we'll be able to take what was done here and bring about the changes that are necessary.

"Whether that will happen or not, well, we'll have to wait and see."

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[4] Buell G. Gallagher, President, City College of New York.

[5] Abraham J. Heschel, Professor of Jewish Ethics and Mysticism, Jewish Theological Seminary of America.

[6] Rev. Philip Potter, Executive Secretary of the Youth Department, World Council of Churches, Geneva.

[7] Charles A. Janeway, M.D., Department of Pediatrics, Harvard Medical School.

[8] Very Rev. Lawrence J. McGinley, President, Fordham University.

[9] Althea K. Hottel, former dean of women, University of Pennsylvania.

[10] Harry M. Lindquist, student, Harvard University.

[11] Talcott Parsons, Professor of Sociology, Harvard University.

[12] Alfred Kahn, Professor of Social Work, New York School of Social Work.

[13] Bertram M. Beck, Associate Executive Director, National Association of Social Workers.

[14] Henry David, Executive Secretary, National Manpower Council, Columbia University.

[15] Finis E. Engleman, Executive Secretary, American Association of School Administrators.

[16] John H. Fischer, Dean, Teachers College, Columbia University.

[17] Karen Sanchez, student, Wellesley College.

[18] Mrs. James C. Parker, President, National Congress of Parents and Teachers.

[19] Irving Gitlin, Program Executive, Creative Projects, CBS News.

[20] Leo H. Bartemeier, M.D., Medical Director, Seton Psychiatric Institute, Baltimore.

[21] Chester D. Babcock, Executive Director of Instruction and Curriculum Research, Seattle Public Schools.

[22] Preston A. McLendon, M.D., Professor of Pediatrics, George Washington University.

[23] Irene M. Josselyn, M.D., Institute for Psychoanalysis, Chicago.

[24] Lester B. Granger, Executive Director, National Urban League.

[25] Leontine Young, Professor of Social Administration, School of Social Administration, Ohio State University.

[26] Earl J. Beatt, Executive Director, Family and Children's Service, Minneapolis.

[27] Paul A. Harper, M.D., Professor of Public Health Administration, Johns Hopkins University School of Public Health.

[28] Herman E. Hilleboe, M.D., Commissioner, New York State Department of Health.

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[30] William G. Carr, Executive Secretary, National Education Association.

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# HIGHLIGHTS OF THE RECOMMENDATIONS

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ON WEDNESDAY NIGHT, March 30, 1960, 68 topic teams finished their task of preparing recommendations for presentation to the 18 White House Conference Forums from the 1,600 recommendations sent in from the workgroups. Later that night, the results were turned over to a crew of typists who worked until dawn putting each group of recommendations into form for consideration in one of the 18 Forums that afternoon. (See page 84.) But first, Forum committees looked at the recommendations to attempt the job of eliminating duplications from the topic teams.

At 2:30 that afternoon, the Forum groups met to vote on the recommendations. Some of the Forums adjourned, as was the plan, at 5 p.m. Some of them were still hotly debating issues nearly 2 hours later.

On Friday morning, April 1, Dr. Ruth A. Stout, Director of Field Programs, Kansas State Teachers Association, Topeka, told the conferees at the final plenary session at the National Guard Armory that the task assigned to her of appraising the significance of the Conference in the light of the recommendations had proved to be impossible. She told of spending the night attempting to categorize the meaning of the recommendations. Saying that a few of them seemed too insignificant for consideration, she added that she had found a universal conviction in this vast welter of words that "no child is too insignificant for consideration."

In their eagerness not to ignore a single facet of the lives of children today and tomorrow, the participants had gone overboard to be sure that their beliefs were represented: their beliefs in the essential dignity and worth of each individual.

Here, in brief, are some of the recommendations:

**Federal Action:** Numerous recommendations called for increased or new forms of Federal financial aid. Among them were: Federal support to education, which when combined with increased contributions from existing resources would total at least 10 percent of our gross national product; Federal aid to schools in desegregated school districts; strengthening the Office of Education with staff, facilities, budget, and status, sufficient to fulfill Federal responsibilities for encouraging and stimulating the development of complete programs of service for exceptional children; State and Federal aid for the education and training of the mentally handicapped; extension of Federal grants for preventive health and welfare services to the States in proportion to the number of migrant farmworkers and their dependents; appropriation of funds already authorized by Congress for training and research in public assistance; expansion of technical assistance to other countries in all areas of child development and growth; additional Federal funds for training workers in family and child welfare services.

Additional Federal funds were also asked: to expand the program of the National Defense Education Act to help communities establish psychological and guidance services in elementary schools; to permit the Children's Bureau and the Office of Education to undertake research and technical assistance to States and local communities and to permit the Bureau of Public Assistance to make grants on the

basis of actual family needs; to allow the Children's Bureau to promote surveys to define and locate physically handicapped children and to analyze and coordinate programs.

Other recommendations mentioning the Children's Bureau were: Promotion of the Bureau to a major agency of the Department of Health, Education, and Welfare, directly under the Secretary; freedom for the Children's Bureau to make research grants directly to institutions or individuals; leadership by the Children's Bureau and a representative group of national professional organizations in recommending standards and scope of care for handicapped children and youth; experimentation by the Children's Bureau and the American Medical Association with new ways of giving health supervision to children living in sparsely settled low income areas; dissemination to localities by the Children's Bureau and the National Institute of Mental Health of materials concerning the nature, detection, and treatment of the emotionally disturbed; appropriation of Federal funds to establish effective, aggressive public educational programs regarding emotional disturbance in children, to be carried out by the National Association of Mental Health and Federal agencies such as the Public Health Service and the Children's Bureau; extension of Federal training activities to include all personnel concerned with juvenile delinquents, by a method to be jointly worked out by the Office of Education, the National Institute of Mental Health, and the Children's Bureau.

A number of recommendations suggested the creation of new Federal agencies or programs, including: Establishment of a National Human Relations Commission, with branches at State and local levels, to encourage research and formulate program and policy; establishment of a National Institute of Social Health to promote social justice for children and youth; the designation by the Department of Health, Education, and Welfare of a Rural Community Counselor to help communities improve the quality of their facilities and services to children and youth; establishment of a Division of Urban Affairs within the Federal structure to plan services and research needed by urban areas; development by the Federal Government of a research program in education comparable to the programs of the National Institutes of Health; institution by the Department of Defense of a policy requiring service personnel to meet their individual obligations to their children born out of wedlock in foreign countries.

Other recommendations involving the Federal Government were: Allocation by the FCC of more very high frequency television channels for educational uses; more direct and accelerated attention by the Federal Government to the needs and handicaps of American Indian children living on reservations; abolition of the quota system in immigration laws, which discriminates against ethnic and racial groups; cooperation of local, State, and Federal governments in helping establish a system of education, resident work centers, and camps, to give out-of-school youth useful work experience; coordination within the Department of Health, Education, and Welfare of the planning and administration of training programs to develop a consistent public policy on manpower for health, education, and welfare.

**Human Rights:** Support of the principle of integration in education; revision and expansion of professional educational curricula to help alleviate prejudicial attitudes and more adequately reflect the cultural contributions and interdependence of all Americans; elimination by church, fraternal, and social organizations of restrictive admission criteria discriminating on the basis of race, color, or origin; elimination of discriminatory practices by labor unions, employers, and employment agencies; creative activity by voluntary and community agencies to encourage and promote interracial and interreligious understanding; passage of State and local laws prohibiting discrimination against minorities in the sale and rental of public or private housing; support of the nonviolent sit-in demonstrations of students in protest against segregated facilities; expanded research on the effects of segregation and discrimination in both majority and minority groups; requirement of courses in human relations in high schools and colleges; elimination of discrimination in the availability of public health and welfare facilities; establishment of a national agency to study the transition of youth of minority groups from schools to adult life.

**Education:** Revision of school curriculum to encourage potential dropouts to remain in school; flexible programing and revision to meet the special needs of gifted children; gearing educational programs to the specific developmental needs of early adolescents; inclusion of kindergartens as an integral part of tax-supported public school systems; an increased and improved use of television and radio in classroom instruction to supplement instruction by teacher; increased Federal support for the advancement

of the social and behavioral sciences; requirement of a minimum of a bachelor's degree and State certification for every teacher; inclusion of education for family life in the school curriculum at all age levels; increased salaries and recognition for teachers; reevaluation of the present curriculum for physically handicapped children in the light of their prevocational and vocational needs; research to help schools group children in line with their learning capacities; the release of children from school during school hours to attend religious classes.

**Family Life:** Expansion of family counseling services by social agencies; establishment of mental health clinics; efforts on the part of clergymen and physicians to help families resolve problems of interpersonal relationships; education for parents in developmental changes and problems of early adolescence; availability of homemaker service to families in time of need; establishment of family courts staffed with competent social workers, psychologists, and counselors; State action toward uniform marriage and divorce laws; efforts to preserve continuity in family relationships in treating and caring for children with handicapping conditions; a focus on the family as a unit by all health, welfare, housing, and recreation agencies; provision of supplemental child care services for parents of preschool children, such as day care centers, nursery schools, kindergartens, and summer day camps; provision of intensive casework service for all families receiving financial assistance; a study of family allowances as a way of undergirding family life economically; research on all phases of family life; research on "hard-to-reach" and "multiproblem" families for early identification, causes of their problems, and treatment methods; availability of facilities and programs on a public or private basis to married couples providing medical advice and services for child spacing "consistent with the creed and mores of the families being served."

**Illegitimacy:** Removal of provisions which restrict or deny public social services to needy children born out of wedlock, and accessibility of services for the unmarried mother; a nationwide program to interpret the needs of children born out of wedlock; State legislation to ban noting illegitimacy on a birth certificate; research on the cultural patterns into which many illegitimate children are born that conflict with present standards of society; research into the causes of the rising rate of illegitimacy; the removal of statutory provisions or administrative regulations denying public assistance and other public social services to children born out of wedlock and their mothers.

**Migrant Families:** Development of adequate educational opportunities for the children of migratory workers; extension of minimum wage laws to cover such presently exempted industries as migratory and resident farm labor; placement of responsibility for adequate living conditions for migrant workers on the contracting grower, with Federal and State protection at least equivalent to that given migrant farm labor imported from other countries; provision of classes in family care and nutrition for migrant mothers; registration of migrant crew leaders by Federal and State Governments; enactment of State housing codes to provide decent housing for migrants, based on recommendations of the President's Committee on Migratory Labor; appointment or reactivation by Governors of State committees on migratory labor to safeguard health and welfare of migrant children and their families.

**Children of Working Mothers:** Availability of family homes for day care meeting good social and health standards for all children needing them; care of children under 3 in their homes in so far as possible; provision of family day care and homemaker services for infants who cannot be cared for by their own parents during the day; availability of social case work and other professional counseling services to help parents decide whether the mother's employment will contribute to the family's welfare; encouragement of industries to examine the problems of working mothers in relation to the possibilities of providing part-time jobs or shorter workweeks; research to determine the effects on children of all ages of mothers working outside the home.

**Adoption and Foster Care:** Inclusion in foster care programs of an effective method for early final termination of parental rights; encouragement of research in the field of adoptions with private and public funds; avoidance of unnecessary delay in making adoption placements; efforts to bring about uniformity in State adoption laws; frequent reevaluation of foster home placements to assure return of the child to his own family, if possible, or if not, placement in some other suitable permanent family home; provision of more and better adoption services for preschool-age children; provision of the

same safeguards usually given to adopted children in this country to foreign children being adopted by U.S. citizens here or abroad; provision of State standards, inspection, and licensing programs for all types of group care of children away from their homes.

**Juvenile Delinquency:** Dissemination of informational summaries of laws of major concern to youth and parents; establishment in communities of a central agency to pool relevant information on problem behavior of children and youth, with the full protection of confidentiality; new approaches to treatment and rehabilitation, with provisions for self-evaluation; more attention from the medical profession, including private practitioners and public health personnel, to efforts to prevent juvenile delinquency; establishment in each State of a central body to coordinate community efforts toward the prevention, treatment, and control of delinquency, and improvement of methods for early detection of delinquents; avoidance of applying such labels as "delinquency prone" and "in danger of becoming delinquent" to children on the basis of prediction scales and devices; further development of predictive devices for early identification of children who are likely to become delinquent; provision of courses in family and juvenile law in the curricula of law schools.

**The Handicapped:** Greater use of existing knowledge to prevent handicapping, whether from accident, illness, or congenital or developmental defects; adequate counseling programs for handicapped children and their families; uniform recording and reporting on children with mental handicaps; availability, through public health services or hospital laboratories, of programs for the diagnosis of conditions which may produce mental handicaps; consideration of neuropsychiatric disturbances in mental health clinics to give greater emphasis to the needs of the mentally retarded; financial assistance to provide nursing and medical services for mentally handicapped children, as needed; provision of all basic health services to handicapped as well as to normal children; education of physically handicapped children in regular classrooms whenever possible; continuing use of standardized procedures for reporting fetal deaths, the occurrence of congenital abnormalities and birth injuries, and the handicapping conditions discovered in infancy and childhood; research to analyze the cost of care of children with handicapping conditions; a program to foster the international exchange of research findings and skills required for services to handicapped children.

**Health Protection:** A forceful attack to lower infant mortality and morbidity among American Indians and other minority groups through approaches which take into account their cultural characteristics; reevaluation of school health services with the view of providing improved instruction in health education and continuity of preschool and school health records; requirement by States or localities of inoculation of children against communicable disease; provision of periodic health examination and continuing medical and dental care for all children; widespread establishment of community health councils on an interdisciplinary basis; fluoridation of public water supplies; initiation of crash programs of accident prevention by State and local health departments; survey of the incidence of venereal diseases, with institution of appropriate educational measures to combat their rise.

**Research re Youth:** Research to collect information nationally on volunteer services performed by youth; to study the effects of the peacetime compulsory draft on youth; to study the reasons for early marriage; to continue the study of adolescence with a view to implementing and expanding needed programs.

**Training:** Provision of funds for stipends and training facilities to meet the acute shortage of adequately trained personnel in the professions serving children; extension of ancillary programs into every possible discipline to relieve the professionally trained person for the more responsible tasks; thoroughgoing study by governmental and voluntary agencies of the adequacy of existing training programs in the light of rapid advances in knowledge; increased training of medical personnel in problems concerned with the family, particularly interpersonal problems and family disorganization; readily available inservice training to keep professional practice consistent with new knowledge and developments; provision of increased salaries, prestige, and fringe benefits as incentives to attract and keep competent personnel in social engineering; establishment with Federal funds of a broad program of fellowships to meet shortages of personnel in professions serving children, youth, and parents.

# YOUTH HELPS RUN A CONFERENCE

SUSANNA MATTHEWS

*Member, President's National Committee for the White House Conference*

WE 10 YOUNG PEOPLE who a year ago last December found ourselves thrust into the planning of a national conference involving 7,600 people hardly imagined what the Golden Anniversary White House Conference on Children and Youth would be.

At that time it was difficult to know even what our role on a committee with 72 adults would be. Of course it thrilled us to receive a telegram from President Eisenhower, appointing us to the National Committee. But what would be the full impact of this telegram? Could youth really contribute to the planning of this Conference?

When we came together for the first meeting of the President's National Committee in December 1958, we questioningly stared at each other and gaped at the adults, most of whom were prominent nationally. "What can I ever contribute?"

Most of us had already been working on the State and local levels in followup of the 1950 White House Conference and had done some precommittee planning for 1960. Being a member of the Michigan Youth Advisory Council, I had had a chance to work with adults on traffic safety, juvenile delinquency, and teenage drinking. As a member of the Michigan Youth Commission, working as a liaison between youth and adults, I had looked at youth problems in relation to possible legislation. In March 1958 I went to Chicago to the Joint Conference on Children and Youth sponsored by the Interdepartmental Committee on Children and Youth, the Council of National Organizations, and the National Council of State Youth Committees. At this conference we learned of the plans for the 1960 Conference and suggested ideas for theme and program. We also recommended that youth be on the National Committee—little realizing that some of us would be appointed.

I had met some of the adults on the National Committee in Chicago. But arriving in Washington for the first committee meeting, I felt very inadequate.

It was not long before I realized that all of the adults were vitally interested in my problems and the problems of youth throughout the country. While representatives of various professional fields, they recognized that "each man is a layman in another man's field," and it was from this premise that we began our work.

Each member was appointed to a special subcommittee of the whole committee. Youth were involved in all committees except the finance and executive committees. On the finance committee at least, experience in finances was needed—experience which few youths would have had. The executive committee demanded time that few students could afford to take away from their studies. The main concerns of the 10 of us seemed then to be interpretation of the Conference, followup, and youth participation.

I, being a member of the youth activities committee and of the committee on organization and arrangements, had more opportunities for real participation than did most of the young people. The adults were always eager to hear what I had to say. Some of the other young members on the National Committee felt they had not had the chance to contribute or at least they were not listened to.

There were such comments at the Conference as:

"What good did we do? We didn't even get to plan the youth sessions."

"No youths even sat on the platform Sunday night."

"Our committee didn't even have any meetings."

Several felt they had gained nothing from being on the National Committee; yet, I cannot help but feel that if they had only looked for the opportunities they were there. Meeting outstanding people, seeing the Government in action, learning how to think and say what we felt—all these educational opportunities were provided to us. And better yet we had a vote on what kinds of meetings we would have, the topics we discussed, and special events to hold.

Looking back to the recommendations of the youth at the 1950 Conference, we determined that youth at the 1960 Conference would work together with adults rather than being a separate group, though we expected some problems. Since 1950, youth-adult participation has changed a great deal. Instead of youth groups and adult groups working separately on the same problems, we now find many groups in which youth and adults work together. While still in experimental stages in many places, such association seems to be effective. The young people benefit from the experience and wisdom of the adults and the adults gain from the enthusiasm and fresh opinions of the youth.

On the State and local levels young people had been working in large numbers on "little White House Conferences." Asked to help with State planning for the White House Conference, many of us had spoken to regional groups about the plans for the national conference and particularly on youth's role in it. In Michigan, I helped to orientate the Michigan youth coming to the Conference. National Committee members, including the 10 youth members, had spoken to local PTA's, church groups, and campus groups. Some of us had appeared on television, and others were interviewed by the press. Since youths were used a great deal locally, we felt that it was necessary to keep moving in this direction and that in order to increase youth-adult participation throughout the Nation a national conference of this kind must take the lead. However, early in our planning we also realized that youths were not going to be satisfied to sit in meetings with adults all day and have nothing special to do at night. We did not want to isolate them, but age differences indicated needs for different social activities. Young people do not seem to be happy either unless they have something to do every minute. It was in this area of youth activities that we youth members of the National Committee contributed the most.

On Sunday, March 27, close to 1,200 youths and young adults arrived in Washington to meet with almost 6,000 adults. Sunday was a day of fun for most of us, but at 9 o'clock on Monday the work began. The afternoon work groups brought about the first discussions. On this first day, the youth, uncertain about their dealings with adults, hesitated to contribute and preferred to sit back and listen. Monday evening, the youth I talked to were totally dissatisfied with the proceedings of the day. The main complaint was that "all the adults did was sit and argue . . . we might as well go home now—they don't want to hear what we have to say." In impromptu discussions, groups of youth resolved that tomorrow would be another day—"We'll go in and show them!" Talk of what we would like to see come out of the Conference commenced—and small groups here and there acted quickly on their beliefs. "The adults don't know our concerns—they "talk about what to do but they don't know what *we* really want to do."

### *Working Together*

To be sure there were those who felt they had been heard but seemingly they were in the minority. There was obviously discontent among the adults, too—as they discovered they were "getting nowhere fast." Tuesday seemed to slowly draw the two groups together—and both young and old concentrated on getting something done. But other difficulties cropped up as the two groups began to work together. Some of our young friends had declared themselves "spokesmen of youth" and were on their feet every chance they could get, pushing those adults still not so sure about youth participation further to the defensive. The adults who marvel whenever youth speak nodded in amazement as our friends expounded lengthily about nothing. Tuesday, too, then brought unhappiness.

Wednesday, workgroups grasped the task of formulating recommendations. At last, youth and adults had found their roles and each person saw his role as an individual. Here it was that the minds finally met as people realized they must come out with something. The 1,600 recommendations which came through their workgroups to the Forums were products of wisdom and experience combined with enthusiasm and freshness.

Although an understanding between youth participants and adults was finally achieved Wednesday in the workgroups, some small yet significant problems still existed. Looking around the meeting rooms, one would see a group of young people sitting together and another group of adults together. In



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restaurants, young people ate together and another table was surrounded by adults. In other words, communications between adults and youth in the social world were still missing. I'm not sure if this is good or bad. As I pointed out earlier the young have different social interests than adults. However, if these conflicting social interests interfere with friendships between adults and youth, then they can prevent true understanding and respect.

The worry that youths were being excluded seemed to be the catalyst for bringing youth of different States and organizations together.

Another seemingly small problem arose from the age and experience range of the young people in the Conference. The interests and concerns of the high school student and the college student are significantly different. The high school student is usually still trying to find himself and worries about the problems of the family, dating, and career. On the other hand, the college student, usually having found himself, is bothered by world and national affairs including foreign and domestic policy and education. He also experiences concerns similar to those of adults, involving developing values and ideals and improving cultural and educational facilities. Young people who are employed have still other interests—labor and economics.

The range of experience in working in public affairs complicated the matter of youth participation even further. Young people who had been involved in national programs seem to have discovered years ago things which some of those who had been involved only locally are just beginning to notice. Thus, it is very difficult for youth to present a united front. Young people because they are still involved in their own particular problems find it hard to evaluate the whole field.

One high school boy, for example, could not understand why mass media should be a concern. Civil rights seemed of little importance to him. His greatest interests were in discussion on the family, juvenile delinquency, and preparation for marriage. Another boy, in college, was engrossed with problems of civil rights and education and regarded juvenile delinquency and the family as relatively unimportant concerns.

Thursday evening offered all youths and young adults a chance to consolidate their areas of concern into priorities. Suggested priorities for achievements in the next 10 years were presented in a document drawn up by 18 youths each representing a different forum. As the session drew to a close, many youths looked back over the week—and laughed—for they saw that not only adults argue over silly things but youths do so, too. We did take a united stand, however.

What can this be attributed to? Perhaps the few young adults and working youths in attendance were outnumbered. Or maybe the young adults, working youths, and college students together overruled the high school students; or more probably, the youths decided it was time to take a firm stand on important issues which the adults had hinted at, but had done little about. At any rate, the young people challenged the adult idea that youths are concerned with only their own small problems. They challenged the adults to reevaluate their own positions.

I am convinced that not only 1,400 youths are behind these priorities but thousands of others. I am convinced that thousands of high school and college students across the land are ready for the firm stand taken by their representatives.

### *Youth Priorities*

Civil rights became the number one priority. In calling for substantial completion of school desegregation by 1970, equal access to housing for all individuals, and the elimination of practices discriminating against minorities the youths demonstrated that they wanted to move ahead—and fast. "In due time" was overwhelmingly defeated when proposed as a substitution for "by 1970" in connection with school desegregation. Affirming the right of all citizens to peaceful protest and nonviolent resistance the youth of the Conference set out to destroy social injustice.

Our list of priorities for Conference recommendations was not just something which happened to come up but was the result of many hours of thought and discussion. Though declarations supporting the Negro student sit-ins in the South did not achieve priority status, petitions in their regard made known the intentions of the younger generation. Not only was our civil rights stand significant in itself, but also in pushing the adoption of similar recommendations by the Forums (composed of both youth and adults). Without the work of the young people, the adults might never have taken such stands.

Our second priority asks for reemphasis of the family as a central force for democracy and education of youth in the role of the family. Because we will soon be the generation of parents, this stand may indicate there will be a reemphasis of family life in the United States.

Young people are ready for better education, as indicated by their third priority. They demand that individuals, businesses, and local, State, and Federal governments all do their share. Recognizing the problems we face in education today, we want to stop criticizing our educational opportunities and do something constructive to better them.

We accepted in our fourth priority "an obligation to support and participate in positive national policies for the attainment of world peace with justice, support of human rights, the development of world understanding through exchanges and cooperative nonmilitary assistance." Thus, we are not concerned only with ourselves but with our Nation and our world.

I do not choose to list all the priorities but would like to point out one more which illustrates one other idea. "We demand that high quality books, music, cultural attractions, radio and television programs, and libraries be widely available and that mass media take the responsibility for informing and educating youth, as well as adults." Rather than criticizing mass media, youth has again preferred to take the positive approach. We may be idealistic; yet no one ever gained anything who did not aim high.

### *Problems Ahead*

We have taken our stands—now we must do something about them. We cannot let our chief concerns die in 3 weeks, but must continue to participate and act in these vital areas. Both youth and adults must work together or we will go back to an idea brought out frequently in State reports to the Conference—that what youth and adults want are two different things. Followup then will be a place where youth can and must participate.

In spite of these priorities, which could be the most valuable part the 1960 Conference, realistically we still have several problems confronting us. One is that young people while adding vitality to policy discussions do not have the wisdom, experience, or connections to implement their feelings. Adults are necessary. They always have been and they always will be. Therefore we must help our young friends who jeopardize our relationships with adults by showing them when to participate—and when not to. Some young people have worked very hard for many years to get the voice of youth heard. They have purposely moved slowly, only to see their relationships threatened by the aggressiveness of one youth who thinks he "knows everything."

We, who are young now, are obligated when we become adults to remember how we felt as youths. If we earn a position of equal participation for ourselves, but close it to the next generation, where will we be? They will have to start all over again with obstinate adults who are today "struggling youth."

Some of the youth participants in one of the many extemporaneous caucuses held by young people during the week.

Recognizing that both youth and adults contribute to the problems, I feel that the one last barrier which must be removed is the fact that adults like what we say only as long as it is what they want to hear. To correct this demands clear-thinking, respectful, broadminded youth—and understanding, respectful, broadminded adults.

We have come a long way in youth participation since the first White House Conference in 1909. In order to promote still more youth participation and responsible action with adults, we must continually evaluate our roles and be worthy of the opportunities now open to us. Perhaps this is best summed up in the preamble to our priorities:

"We, as youth, recognizing that meaningful action must be based on a sense of purpose, religious beliefs, personal values, and shared ideals, are fully aware of the gap between reality and our goals. We believe that the deepening of individual values and attainment of our common ideals can be achieved only by a realistic appraisal of, and active participation in, the major issues now challenging us."

The 1960 White House Conference has challenged youth to responsible participation in public affairs. We must strive to make this challenge effective.

# These Are Our Children

A popular feature of the Conference was the exhibit of more than 250 photographs showing young people of this country at play, at study, at work, in trouble—in short, living. From the files of newspapers, magazines, news services, and Government agencies, the pictures were gathered together and displayed with the technical assistance of the Eastman Kodak Company.

# CONVERTING WORDS INTO ACTION

EDWARD D. GREENWOOD, M.D.

*Chairman, Followup Committee, President's National Committee, Golden Anniversary White House Conference on Children and Youth*

THE GOLDEN ANNIVERSARY White House Conference on Children and Youth has just been concluded. Planners, speakers, workgroup leaders, participants, all are now engaged in an active appraisal of the Conference. Was it worth the time and effort spent on it? Did it accomplish the goals set forth? No one can answer these questions in full because the real measure of a conference such as this depends, in large part, on what is done with the findings and recommendations.

The momentary stimulation experienced while listening to an inspiring speaker, the desire to rush home to embark on a program discussed in a workgroup can be but fleeting emotions unless adequate help, information, and leadership are available. Realizing this, the President's National Committee for the Golden Anniversary White House Conference from the beginning included Conference followup in its discussions. And on its recommendation, made last October (see CHILDREN, January-February 1960, page 34), a National Committee on Children and Youth was established prior to the termination of the Conference's Washington meeting in March. Purpose of the new committee is to followup the Conference findings when the President's National Committee dissolves sometime before October 1960.

Composed of 20 members, the new committee has five representatives from each of the organizations involved in the Conference planning: the President's National Committee; the Council of State Committees for Children and Youth; the Council of National Organizations on Children and Youth; and the Interdepartmental Committee on Children and Youth. [See box, page 103.] These 20 members come from both public and voluntary organizations. A steering committee of the new National Committee is now at work defining the committee's functions and reviewing the legal aspects of transferring resources from the President's National Committee to the new committee. To obtain any funds remaining from the White House Conference operations, the new committee must present its plans for approval to the President's National Committee before the latter dissolves.

The creation of the new National Committee is a recognition of the long-existing informal coordination among the three councils representing the States, the national organizations, and the Federal Government. This type of coordination is continued in response to a widely shared feeling that a large national organization with a great deal of fanfare is not needed to do a good job in followup; that what is needed is an organization which can provide catalytic action for all groups which have an interest in seeing that a better job is done for children and youth.

The activities of the National Committee will probably include, first, development of a clearinghouse for information—information which might be common knowledge in one State or community and yet be entirely unknown in another.

This clearinghouse function would provide a way for a State to become aware not only of what other States are doing, but also of what national organizations and the Federal Government are doing or planning that will affect its children; and the reverse.

The National Committee may also help States, communities, and organizations to achieve a consistent quality in reviewing what they are doing or have done. It may help them see how an activity can be reported in a way that will convey the true picture of what is being done or what measure of success is being achieved, so that the experience can be useful to others. Some reports distort facts and gloss over

failures in an effort to achieve a glowing picture. On the other hand, some groups do valuable work and produce results but fail to publish and disseminate reports of their work. The exchange of honest reports of followup efforts can be an important step to further achievements.

The new National Committee can, however, be more than a clearinghouse. Through a widespread educational program, it can help the public become acquainted with the findings of the White House Conference so that people will look in their communities for areas which need attention. An educational program which is simple and direct can stimulate interest and feelings of responsibility among the people whose support is necessary for the achievement of goals. It can do this by focusing attention on a specific problem, a particular course of action, a single goal. However, this can only be effective if the goal is described in relation to other problems and approaches with which the community is concerned.

Among other functions for the new National Committee which have been suggested in meetings of the steering committee are: the direct publication of informational material, such as the *Conference Reporter*, now published by the White House Conference staff; finding ways of maintaining consultation services to States on White House Conference followup through stimulating the use of the facilities of Federal and national agencies or providing direct consultation in response to requests; instigating research; and promoting and assisting in carrying out regional and district conferences on children and youth. Which of these suggestions, if any, will be included in the steering committee's report to the full committee is as yet undecided. When completed the report, which will also include suggestions on staffing and structural details, will be reviewed by the Executive Committee of the President's National Committee as well as by the new National Committee before being sent to the President's National Committee for approval.

### NATIONAL COMMITTEE FOR CHILDREN AND YOUTH

Representatives from the President's National Committee for the White House Conference: Mrs. Rollin Brown; Luther H. Foster; Edward D. Greenwood, M.D.; Mrs. Thomas Herlihy, Jr.; and Roy Sorenson.

From the Interdepartmental Committee on Children and Youth: Edward W. Aiton; Helen K. Mackintosh; Beatrice McConnell; Katherine B. Oettinger; and a fifth representative, still to be appointed.

From the National Council of State Committees on Children and Youth: Donald Brieland; Sylvia Carothers; A. Whittier Day; Mrs. J. A. Hill; and Donald S. Howard.

From the Council of National Organizations on Children and Youth: Lyle W. Ashby; Robert E. Bondy; George Corwin; Debra Partridge; and Philip E. Ryan.

### *State Action*

The primary responsibility for followup of the Conference findings, of course, rests with the States and communities which must view them in the light of their own needs. Many States already have strong, active committees on children and youth, which must now devote themselves both to sustained effort in their current on-going programs and to implementation of White House Conference findings. Some already have plans well underway.

Some of the States already had set dates before the termination of the Washington meeting for little White House Conferences to be held in their State capitals shortly after their White House Conference delegations returned home. Indiana, for example, is holding such a conference this month. The purpose of such meetings is to review the State's report to the Governor in the light of the White House Conference findings, to set priorities for action on a State level, and to stimulate similar reviews and appropriate action within local communities.

In a number of States the structure for followup action on the White House Conference—as well as for continuing review of children's needs and of plans for meeting them—has already been established by the Governor. In some, Missouri for example, a long established commission, council, or committee on children and youth which preceded and worked with the State's committee for the White House Conference has been assigned the followup task. In others, for example Michigan, the State's liaison group for the Conference was a long established, official committee on children and youth for which Conference followup will be a natural function.

In Florida, where the Florida Children's Committee has been in operation since 1947, a little

White House Conference created a coordinating group, to carry somewhat the same functions within the State as the new National Committee will nationally. Composed of representatives of public and private agencies and statewide adult and youth organizations, the new group will serve as a clearinghouse for legislative information and for information on programs and needs. It will hold biennial meetings and will require written reports annually of its members. The Florida Children's Committee will serve as the new coordinating group's steering committee.

In Tennessee, followup is to be stimulated by a new State committee composed of the 64 State participants in the Conference at Washington. The committee members, each of whom will also serve on a county committee, will meet once a year beginning this May to discuss priorities for and methods of county action. Its executive committee will be the legislatively established Tennessee Commission on Youth Guidance.

In some States where no statewide committee on children and youth existed prior to the Conference, the Conference has proved to be the stimulation for the formation of a permanent group. This is what is happening in Nebraska.

If the Conference is to produce results which have meaning in the lives of children, such statewide committees will have to continue to survey the needs in their States and to help local communities with self-evaluation and action. The State reports made in preparation for the White House Conference should be regarded as the beginning rather than the conclusion of statewide citizen action in behalf of children. Unless there is already another functioning, widely representative committee on children, the committees appointed for the 1960 Conference should continue their operations, either as official bodies, or, if they are officially dissolved, as voluntary organizations of citizens who are interested in improving the health, education, and welfare of children.

### *For All Children*

The youth participants in the Conference, with the usual directness of youth, have made some valuable suggestions and recommendations. We hope they will follow through and disseminate this information to all the youth organizations in the country. We hope too that they will continue to be given opportunity to act in cooperation with adults. These young people are the essential nucleus for future Conferences. What they do may have an important effect on the future of their communities and States and on the future of our Nation.

The fact that over 1,000 recommendations came out of the 1960 White House Conference means either that we are in a bad way, or we are searching more carefully than previously, or that we are restating problems in different ways. Whichever meaning is correct, it poses for the new National Committee a major responsibility for helping to group these recommendations so that they can be put into a usable and workable form and to try to develop a broad design for priorities.

The conversion of words and ideas into suitable action is a difficult problem. Selection of a project and the willingness to move together in a given direction toward an agreed-upon goal demands intelligence and maturity on the part of a community's leaders. The problems themselves, whether related to children suffering from cerebral palsy, mental retardation, polio, or emotional disturbance, or to promoting positive opportunities for all children, have to be viewed critically as part of the community in which they exist. They cannot be taken out of context through national or State decrees. For example, the establishment of a better treatment center for emotionally disturbed children would be useless unless the local community saw the need for it and how it would fit into an overall program for children. Otherwise, a new center might produce more problems than it solved.

The purpose of the Conference—"to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity"—can easily become a mere cliché. Or it can remain a sincere statement expressing a real desire to accomplish what it says for all children of all religions, of all races, of all economic levels, from all parts of our country. This is a complex and distant goal. It can be reached through the efforts of people who encourage themselves and others to broaden their horizons in searching for ways of promoting the welfare of children.

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Let the next White House Conference be on Reforming Adult Behavior . . . And Soon.

*B. N. B., St. Louis, Mo., in a letter to the White House Conference.*

*How have we kept our 1950 pledges? asked a speaker at the 1960 White House Conference. A condensation of her address follows.*

# CHILDREN AND YOUTH IN AN AFFLUENT SOCIETY

EVELINE M. BURNS, Ph. D.

*Professor of Social Work, New York School of Social Work, Columbia University*

DURING THE LAST DECADE we have experienced an increase of about 40 percent in the total volume of goods and services produced in the United States. Although population has also increased sharply in this same period, individual income receivers are markedly better off. Income per head at constant prices, which was $2,300 in 1950, will be about $2,800 in 1960, and in the next 10 years the average is expected to rise to about $3,500.

For our children and young people, this should mean an enhancement of economic opportunity and an assurance of the satisfaction of their material needs. To a considerable extent, this has occurred. If we think only in averages, we do indeed find that children and youth are better fed and their physical condition is improving. Their educational attainments are undoubtedly rising. Job opportunities, too, are improving.

But concentration on averages gives a false impression of the impact of this remarkable good fortune which the Nation as a whole has enjoyed. Far too many of our children and young people have not shared in this increase in economic prosperity. Children on farms have in general been left behind: in 1959 the average income of the farm population was not quite 44 percent of that of the nonfarm population. Geographical disparities in family incomes are still glaring, though there is some indication that they are diminishing. The child living in Mississippi or Arkansas, where the average per capita income is only about half the national average, is unlikely to have access to the material comforts, the better housing and education, or the range of community facilities that we regard as "normal." Similarly, our economic gains have had much less of an impact on the children of nonwhite families. Whether we measure by average incomes, housing conditions, health standards, or educational attainments and job opportunities, the typical nonwhite family has lagged far behind the rest of the population in improvement.

Averages are misleading, too, if we fail to make allowance for the "bunching" of children in families. Unfortunately, income increases as the size of the family increases only up to the point where there are two children in the family. Thereafter, it actually decreases quite rapidly as the family size grows. Fifty-eight percent of the Nation's children are in families with three or more children.

In 1954, the last date for which we have detailed breakdowns, the median income of two-child families was $4,506, while that of five-child families was only $3,155. In that year 19.4 percent of three-children families, 31.7 of the four-children families, 47.8 of the five-children families, and 51.8 percent of the families with six or more children had annual money incomes equal to less than half the amount of the City Workers Family Budget. This is a budget based on a modest though adequate, rather than

either a luxury or a subsistence standard of living.

Averages also conceal the fact that at any given time some families have no income of their own because the breadwinner has died, is unemployed or sick, or has deserted his family. Fortunately our social security system assures income to many millions who find themselves in such circumstances. But there are still too many gaps in the net of insurance protection: the benefits afforded in many instances are very low; in many families the breadwinner is excluded from coverage of unemployment insurance; only four States assure income to families when the breadwinner is temporarily disabled; and families with a permanently disabled father under 50 years old have no social insurance rights.

The thought that public assistance exists to fill these gaps may be a comforting one, but the reality is not very comforting to those who seek such aid. In 17 of our States, public assistance is denied in some or all jurisdictions to families with an employable member. Yet the time during which unemployment insurance benefits can be paid is extremely limited in most States, and there are many "depressed areas" characterized by persistent unemployment. Moreover, many thousands of needy families are denied aid from existing programs because of the operation of residence requirements, anachronisms in a society whose economic system requires workers to be mobile.

For those who are eligible for assistance, the public assistance programs provide monthly payments so low as to condemn the recipients to a life of grinding poverty. It is a curious and shocking irony that, in a nation which talks so much of its concern for the welfare of children and young people, the lowest monthly payments are granted in the two assistance programs where a large proportion of recipients are children. The average monthly payment per recipient of Aid to Dependent Children—with 2¼ million children on the rolls—was $28.71 at the end of 1959, and in some States it was far lower. General relief, where it existed at all, was making monthly payments averaging only $70.97 per case of approximately three persons.

Clearly, the impact of our rising prosperity on the children and youth of this country is very uneven. The economic situation of many children living on farms, of nonwhite children, of children who reside in the poorer States, of children of large families, and of children who are the recipients of socially provided income, especially those supported through the Aid to Dependent Children program, should cause us to hang our heads as we reread the Pledge given to children at the conclusion of the last White House Conference on Children and Youth:

*We will work to raise the standard of living and to improve our economic practices, so that you may have the material basis for a full life.*

The impact of our rising levels of productivity and output upon the Nation's children and youth will, of course, be greatly affected by the forms in which the Nation decides to take its extra economic wealth—by the use to which we in fact put our good fortune. As income receivers, we are in theory free to spend our incomes as we individually wish. I say "in theory" because we are all, of course, influenced by the prevailing culture and values and by our exposure to the powerful pressures of advertising. As voters, we jointly decide how much of our economic resources shall be devoted to the kinds of goods and services that can only be provided by our freely elected governments acting on our behalf and how much shall be devoted to the kinds of goods and services that, as income receivers, we can buy on the open market. The outcome of these two types of decisions is not always what is in the best interests of our children and youth.

A major need of our children is education. In recent decades the Nation has considerably raised its sights as to the level of education we should aim to assure our children. But we have not been willing to allocate a large enough share of our rising productivity to making that promise a reality. True, in 1958–59 school expenditures accounted for 3.1 percent of the gross national product as compared with pre-World War II yearly averages of about 2.4 percent. But even this larger proportion of a larger national output has not sufficed to provide an educational system that meets our current standards. Schoolrooms are overcrowded, many school buildings are antiquated; and teachers are scarce and are likely to remain so until their salaries are brought closer to those offered to workers of similar training abilities and responsibilities. To add to the problem, the school population will grow by 29 percent over the next 10 years. Even if we are to hold our own, to give the children in this larger enrollment an education no better and no worse than present standards, we shall have to devote to this end a larger proportion of our increasing income. And if we are to remove present deficiencies, we shall have to increase the proportion even more.

Or again, we can look at housing. For a nation

which lays so much stress on family life and so properly glorifies the home as the matrix of our culture, our unwillingness to devote an adequate proportion of our wealth to ensuring decent homes for all our families is little short of amazing. In 1956 the Bureau of the Census found that there were 13.1 million dwellings (24 percent of all dwellings) which were seriously substandard. Of this total, 4.2 million were "run down or neglected or of inadequate shelter or protection against the elements, or endangered the safety of the occupants." We must see that a larger fraction of our resources goes into housing (even if it means fewer gadgets or less elaborate automobiles or fewer private swimming pools) if our children and youth are to benefit as they could from our rising economic productivity.

One of the more disturbing developments of our time is the growing evidence of an increasing rate of family breakdown, whether measured by out-of-wedlock births, divorce rates, or family separation or desertion. The tensions of modern society, the complexity of life, and the precarious economic security of some sections of the population have meant that all too many families face problems of management, or of personal or emotional adjustment, in the resolution of which they need skilled help.

We know all this, and yet this knowledge is not reflected in the extent to which we devote resources to strengthening family life. The fraction of national product we devote to such welfare services as child welfare, family counseling, or rehabilitation has remained at .2 percent for 20 years.

In 1959 almost half the counties of the Nation, containing a quarter of our children, had no full-time child welfare worker. And we still use the major part of the meager resources we allocate to child welfare services for dealing with homes already broken, despite all our talk about the importance of prevention and keeping the home together. We complain about problem families and juvenile delinquency, but we do not insist that resources be made available either for training adequate professional personnel to deal with the people involved or for research that would enable us to understand better the nature and causes of these phenomena, and thus to develop more appropriate preventive and remedial measures.

Attainment of an allocation of our growing economic resources that will more surely redound to the advantage of the Nation's children and youth will make heavy demands on all of us. As individual income receivers, we need to reassess our spending patterns. This calls for the responsible cooperation of business, advertising, and the press, and a greater willingness on the part of all of us to support community programs, both voluntary and governmental, adequately even at the cost of reducing the proportion of our private incomes that we can spend exactly as we wish. The steps toward remedying these misallocations of our resources will not be easy ones. Yet we can hardly fail to take them if we are to fulfill the White House Conference's pledges of 1950:

*We will provide you with rewarding educational opportunities, so that you may develop your talents and contribute to a better world . . . We will work to conserve and improve family life . . . We will provide the conditions for wholesome play that will add to your learning, to your social experience, and to your happiness.*

We must also recognize that the very increase in productivity has involved by-products that affect children and young people in other than material ways. One cause of our rising national output has been the increase in the working population. And one source of this increase is the growing tendency for mothers to enter the labor market. In the years 1948–58 the number of mothers in the labor force increased by 80 percent and the proportion of all mothers who work by almost 50 percent. There were at least 3.6 million preschool children by 1957 with mothers in the labor force.

It is evident that when a mother is away from home some form of substitute care for the children must be provided. Yet, in 1958, as many as 400,000 children under age 12 had to care for themselves while the mother worked, and a third of these were less than 10 years old. Thus we are getting at least part of our increased output too cheap—at the expense of the children for whom we fail to provide day care centers, foster family day care, or homemaker services.

Our dynamic productive economic system has another unfortunate impact on children. One of the preconditions for an economic society characterized by rapid change and expansion is that the labor force shall be highly mobile, both occupationally and geographically. But to families and children the cost of this mobility may be high. Consider, for example, the situation of the 380,000 migrant farm workers and their families; their low and uncertain income; their unsatisfactory and often disgraceful housing; the interrupted or complete lack of education of their children; the limitations on their access

to health and social services caused by their nonresident status; and among many of them the toiling of their children in the fields. The children of these migrant families can never hope to develop a sense of stability and security that comes from a feeling of "belonging" somewhere. What of them in relation to our 1950 pledge:

*We will protect you against exploitation and undue hazards and help you to grow in strength.*

One in five of the families in this country move in the course of a year; 13.6 percent of the families whose head is under 35 move to a different county. We do not need much imagination to guess at some of the effects of frequent moving upon the young. In addition to the effects on continuity of education, the loss of, or failure, ever to form lasting relationships with peer groups or with other persons in a familiar neighborhood, the lack of attachment to any community as "one's own"—these are some of the prices paid by children for our economically very important high worker mobility.

Of course, families do not move only in response to job opportunities. Much contemporary movement is due to the effort to secure better housing. Yet even here the impact is not always favorable. The trend to the suburbs has undoubtedly brought better and more wholesome housing and living conditions to several million children. But less thought has been given, in this movement, to the assurance of adequate educational opportunities or provision of community facilities for recreation, worship, and responsible self-government. Nor should we overlook the impact on children of the ever-lengthening "commuting time" daily undergone by the breadwinner. The father who spends 2 or 3 hours commuting to and from his job has that much less time to play his traditional role in family life.

If the movement to the suburbs has not been entirely a net gain for those who have moved, it has been little short of disastrous for many of those who continue to live in the central city. Increasingly, the core of our cities tends to be inhabited by the least economically mobile sections of our population or the newer arrivals. Their ability to afford decent housing is limited, and the capacity of the cities to build more adequate dwellings for them is restricted by the high costs of intracity building and the declining tax yields—caused by the departure of the better-off families and of industries seeking lower taxes and rents. Skyscraper apartments, dictated by economic considerations in building within the cities, are far from the ideal answer to the need for decent family living, especially where children are quite young. Moreover, opportunities for wholesome outdoor use of leisure time recede as the suburbs increasingly fill up the surrounding open spaces.

Worse still, the limited supply of decent housing has been accompanied by what seemed at first sight a reasonable attempt to develop priorities: public housing would be reserved first of all for the most needy, the poorest. In consequence, we now face a situation in which many of our metropolitan housing projects are too largely concentrations of problem or broken families or of people who are not moving upward economically. This, too, is an unfortunate environment for children, especially those in the older age groups. Is this kind of a depressed and one-class environment likely to implement another of our 1950 pledges:

*We will help you develop initiative and imagination, so that you may have the opportunity freely to create.*

Our economic progress has been predicated upon advances in scientific and technical know-how. All labor market forecasts indicate a rising demand for skilled technical and professional workers and indicate that the poorly educated, untrained worker will have increasing difficulty in finding employment. Almost 40 percent more young workers will be entering the labor force during the 1960's than did so during the 1950's. Are we attaching a high enough priority to ensuring that these young people are equipped with the training and skills that will be needed if they are to find jobs?

The task is more than just assuring better education: it also implies a great expansion of guidance and counseling services so that the increasingly expensive and highly specialized training required of workers will be made available in relation to the aptitudes and interests of different categories of young people and the probable long-range requirements of industry; and so that the young people entering the labor market will be enabled to make the best use of their talents and to equip themselves with the kinds of training that will enhance their opportunities for obtaining employment. Only so can we hope to avoid both a waste of valuable manpower and the social problem of unemployed, frustrated young people.

Consideration of the impact of economic developments upon our children and youth also suggests a problem involving values. We may be in danger of

making economic progress an end in itself. Economic achievement and advancement carry social status and approval, and our concept of the good life includes a heavy, and some say, an almost exclusive, material component. These values are inevitably transmitted by our culture to the most sensitive element of our society, our youth.

Condoning as we do the glorification of economic welfare and its use as a status symbol, ought we to be surprised that some of our young people, whose levels of economic aspiration so vastly exceed their actual opportunities of achievement, become frustrated and despairing and work off their resentments in delinquent and antisocial behavior? When the good life is painted as being dependent on the possession of material goods and the attainment of satisfactions that can only be secured through the possession of money, should we be surprised that some young women recognize that these ends can be obtained more certainly by exploitation of their sex appeal than by employment in the low paid jobs that are available to them? And when the social climate seems to condone sharp practice and cheating, can we expect our young people to do other than draw the obvious moral: anything is permitted provided it brings economic success and you can get away with it?

Could it be that hitherto in our planning for the well-being of children and youth we have put rather too much emphasis on what goes on inside the family and the home, important as this undoubtedly is, and too little on the impact of the environment, economic, social, and cultural? Obviously, the influence of the home is of immense importance. It may well be a measure of our success in improving child rearing practices and fostering emotional security that not more of our youth react antisocially against the outside world when they leave the shelter of the family environment. But surely we aim to do more for our children than to equip them to tolerate frustration?

The problems of youth are significantly different from those of children, and our planning must reflect this fact. Youth is a period of looking outward, away from the family, and of assessing the world as it affects one's own future as an adult.

If all our children were assured the kind of home environment and opportunity that we know to be desirable and that our economic wealth makes possible, there would be no need for a White House Conference on Children and Youth. We are here to look facts in the face, to assess our achievements and our shortcomings as they affect our children and youth, and to search for ways of eliminating the black spots that still remain. As we "survey what we do," we shall probably find that some of our failures to attain our objectives are due to limitations of knowledge. There will be facts we need, but do not have as yet, about the extent of problems or their probable causes. There will be uncertainties as to the most effective remedies, and differences of opinion as to the best way to implement a policy even when all are agreed that it is a good one. But there are many problem areas where neither the facts, nor the desirable policies, are in dispute but where we have not yet made use of the knowledge we have.

We owe it to our youth not to evade this sobering confrontation of our stated objectives and pledges with our achievements. For young people are more literal-minded than we, who have already come to terms with the compromises and concessions that we blame on "the harsh realities of the real world." Like the child who saw that the emperor was naked, young people still expect us to mean what we say and to apply our precepts and our policies in everyday life. They are more shocked than we are by obvious discrepancies. More vulnerable to discouragement than we, for their values are as yet less fixed and their experience is briefer, they may react with a dangerous cynicism to the contrast between our achievements and our fine words and pledges about nondiscrimination, equality of access to the good things of life, and opportunities for development.

Let us, therefore, not be afraid to pinpoint our failures and to call upon the Nation—individuals, families, business, voluntary agencies, and all levels of government—to take the steps we believe to be necessary. Thus, even if we have to confess that we have not kept many of the pledges we made in 1950, we may yet live up to one:

*We will illustrate by precept and example the value of integrity and the importance of moral courage.*

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Any expenditure of public funds for community betterment always prompts complaint about the burden of taxation. Never do we hear of the benefits of taxation.

*Theodore Jackson McGee, Chairman, Housing Authority, Columbus, Ga., at the White House Conference.*

*The White House Conference's "leading character"—the growing child . . .*

# MOVING TOWARD MATURITY FROM INFANCY THROUGH ADOLESCENCE

## Some White House Conference Information Sheets

Among the materials presented to the participants prior to the White House Conference were fact sheets giving some background information on the subjects of the workgroups to which they were assigned. The following six papers are the information sheets, slightly condensed, prepared for the workgroups on various stages of child growth and development. These workgroups were attached to two Forums entitled "Moving Toward Maturity," the one concerned with the periods before and the other with the periods after puberty.

## INFANCY

DURING NO OTHER PERIOD of the life cycle are developmental changes so rapid and dramatic as in infancy. We have as a result of the research of the 1920's and 1930's detailed norms on the development of basic capacities in infancy: On the growth of visual coordination; grasping and locomotor skills—creeping, standing, walking; and on the higher order adaptive functions, such as memory and learning. Considerable data have been accumulating during the past 20 years on the significance of experiences during infancy for later development. During the last 10 years much attention has been given to developing appropriate methods for studying infant "personality," and to attempts at more precise formulations of relationships between early experiences and later behavior.

It is difficult to pinpoint the ages at which complex functions and reaction-systems are established, since most of the available measures are indirect ones, requiring interpretive inferences. Even data on the age of directly observable accomplishments, such as walking or uttering the first recognizable word, although they seem to be fairly clear cut, may show considerable variation due to differing criteria. For example, our norm for the age of walking will vary, depending on whether the criterion is the first step or the ability to navigate across a room without mishap.

From birth to 1 year the infant changes from a dependent, essentially passive organism at the mercy of his environment to a toddler capable of responding selectively and with some degree of autonomy. At birth and for several weeks afterward, he probably sees the world as a diffuse, loosely organized mass of stimuli; his responses tend to be global, involving his total organism. During the first 3 months his perceptual capacities develop rapidly: he becomes increasingly capable of respond-

ing selectively; he is able to ignore some stimuli; and his responses become more focused and more appropriately adapted to the characteristics of the stimuli. From 3 to 9 months the infant's control over his environment increases progressively, with the development and refinement of grasping skills and with growing perceptual discrimination. With the achievement of independent locomotion when he is about a year old, the infant enters into a new period of greater autonomy and increasing mastery of his environment.

From birth to 6 months the infant's social characteristics show dramatic changes. From the fleeting orientation to the voice or face of other social beings during the first month, he progresses rapidly to responsive smiling, then to reaching out and establishing social contact physically as well as through rudimentary vocal communication. Very early in life he distinguishes his own mother from other social objects in the environment. Long before he gives evidence of being able to make the simpler discrimination between a square and a triangle, he seems able to make the more complex differentiation between his mother and another friendly woman. Although the ability to make complex sensory discriminations is not apparent before the preschool years, there is much *indirect* evidence that the infant at a very early age is sensitive to rather subtle manifestations of feeling and slight variations in feeling tones in his environment.

How does the infant develop a sense of personal identity, a self-concept? It is assumed that this comes about gradually through the experience of frustration, as a result of his needs not being immediately or completely gratified. Although the optimum dose of frustration is not known, we do know that repeated strong doses of frustration may be harmful. The infant who is constantly in a state of strong need-tension may have difficulty in relating to the outer world, and may become set in the tendency to perceive the outer world as hostile, threatening, or unpredictable. Consistency in handling the infant results in environmental predictability, which may play an important role in the growth of self-awareness and healthy ego-development in the infant.

The importance of the earliest period of life for later development has become part of modern folklore. There are rather clear data indicating that simple learning mechanisms operate even before birth: simple conditioning may occur in utero. Simple associative learning clearly goes on from the moment of birth.

In view of the great plasticity of the infant organism, infant care practices may be highly significant in setting the course of later development. Through learning the infant becomes sensitized to specific experiences: feelings, positive and negative, become conditioned to environmental events. The accumulating evidence, however, does not support the assumption that a single experience, such as early weaning or strict toilet training, is in itself sufficient to have a specific effect. Research findings point to the importance of the total atmosphere in which an event occurs, especially the relationship with the mother in determining its impact.

Research on infant care has begun to shift from exclusive focus on specific practices to the interactive aspects of the mother-infant relationship. It is recognized that the mother's behavior toward an infant is significantly influenced by the infant's unique characteristics.

Data on infants document a wide range of individual differences in basic sensitivities to sound, touch, visual stimulation, and other environmental intrusions: differences in general reactivity; and, possibly, differences in tendencies to externalize or internalize tension. The impact of any given environmental event will be influenced by individual differences in sensitivities as well as by the developmental stage of the infant. The importance of the specific time in development at which an experience occurs has been pointed up by research on animals. Normative data on the characteristics of human infants—their perceptual awareness, their learning capabilities, and their response potentialities—provide clues to changing sensitivities and vulnerabilities at different ages. Finally, there is increasing recognition that the long-term effects of any given experience can be reinforced or attenuated by subsequent events.

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# EARLY CHILDHOOD

EARLY CHILDHOOD is characterized by some behavior which is primarily an extension and elaboration of earlier developments. Children enter this period having recently made dramatic gains in posture, balance, and locomotion. They are, as a result, deeply involved in extending this new-found mas-

tery of their bodies, and seemingly, are filled with almost boundless energy. All opportunities to be active hold great appeal: walking, running, jumping, riding, pushing, pulling, rolling, balancing, swinging, sliding, hopping, skipping. Equally alluring are activities which provide the chance for practice and growing perfection of hand and finger skills and of hand-eye coordination.

In part because of this surge of new physical powers, the child in this period is exceedingly aware of his new-found self. He relishes opportunities for bigness and independence. This concern shows itself, at times, in an overinsistence on making decisions and choices and on having one's own way. It shows itself in a fierce determination to "do-it-myself" in dressing, eating, and carrying out other daily routines.

These independence-conscious children still remain fundamentally dependent. Despite its frequent assertion, the self is not yet sure enough of its own strength to be able easily and gracefully to wait, to postpone, to share, to give in. Especially in times of stress—when hurt, fatigued, frightened—children in this period turn almost automatically to mother or her substitute for comfort, support, assurance. And, at all times they exhibit a steady ongoing deep welcome of any evidence of warmth, love, good humor, and gentleness from the important "big people" in their lives.

Early childhood is also characterized by some behavior which seems new because it stands out so prominently, although it has roots in earlier development—the almost consuming interest in playmates. Home and parents remain the basically important factors in the child's life but to these is added a fascination with other children. This is a highly social period, and friends are very important. At the beginning there is satisfaction in simply being near others; this develops into a zest for being intricately involved in cooperative play. Because of their only recently discovered sense of self and because they are beginners in social intercourse, children in this period are at their best with small numbers of age mates.

Another new development is great verbal output. Children in this period talk almost constantly, even when alone. Noise goes along with all their movement, and seems to delight them. There is much experimentation with words and their effect on people. There is also apt to be some name calling, arguing, and threatening, in part related to the child's deep desire for bigness and in part replacing the kicking, biting, and pommeling of the child's earlier years.

Conversation increasingly involves the give-and-take of ideas, although often children simply take turns talking, not necessarily responding to each other. Questions are numerous, a symbol of the fact that the mind is also exceedingly active at this period. They begin with the simple "Whaddat?" but move on to more complex probing about what things are for, where they come from, what can be done with them.

These children do not simply take the other fellow's word for anything. They want to touch, see, smell, taste, use all their senses for learning. Primarily firsthand scholars, their strongest interest is apt to be aroused by the tangible things that they encounter from day to day.

The dominant new characteristic of this period is the make-believe. Almost everything the child does—his social activity, his physical activity—is thoroughly stamped by his imagination. Most commonly, the jumping-off point for dramatic play is some part of the real world to which the child's curiosity has led him. Whatever form the make-believe takes, however, one of two tones, reflecting the underlying concerns of the child, is apt to pervade it: The child is either in a role of the big and the strong or the powerful, or in a role of where he can be small, protected, and dependent. The child's play is always marked by the kind of absorption, intensity, and attention span that is associated with adult hard work.

Early childhood is also characterized by some behavior which foreshadows what lies ahead. The children remain quite impulsive, egocentric, and full of themselves throughout the span, but toward the end of the period, there are many evidences of growing awareness of what others want and of growing desire to please others. Sheer manipulation of and experimentation with materials continues. However, the gradual development toward representation in children's paintings is one evidence, among many, that the child in this period begins to use the power he has been building up to fit into a real world of real things.

Imagination persists strongly throughout early childhood, but an interest begins to emerge in simple games that are played by fixed rules. While physical activity and sensory experiences continue to delight, there slowly develops a selective awareness of symbols, of words. Having found the world enticing through their explorations, having found adults trustworthy and good and their own peers satisfy-

ing, having found their own strength, children emerging from early childhood give signs of being comfortably ready to move further out into the world.

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# THE EARLY SCHOOL YEARS

IN THE EARLY SCHOOL YEARS, as the child loses his baby teeth, his physical appearance alters in ways that quite accurately mirror the inner changes taking place. At age 6 he is moving away from the close ties with his family into the more impersonal spheres of school and neighborhood. He has to learn to measure up to two new sets of standards: Those of society at large, as embodied in the school, and those of the society of children, which he is now entering. Acceptance into the latter requires that he demonstrate his skill or prowess, master the tribal lore of chant, game, and ritual that is passed from childhood generation to childhood generation, and observe the code of the peer group—"No snitching to the grownups!"

Today with the spread of preschool education, many children move out into the world earlier and more gradually than before, but ages 6 and 7 are still a time of important transitions and hence of considerable anxiety. By the age of 8 or 9, children have usually achieved the smooth competence and self-assurance that mark them as fully established in the middle years of childhood.

The child takes over the new sets of standards and applies them, often with undue harshness, to himself. Although at 6 he still sees adults as wonderful, all-powerful beings, he is developing both a strong sense of privacy and a close affiliation with his peers. For a 7- or 8-year-old the worst "sin" is to be in any way different from other children. As a result, he doggedly applies himself to learning the games, chants, rituals, jokes, riddles, and stunts of this period, and to acquiring the skills that mark him as a full-fledged member of the neighborhood "gang." He apes the dress and mannerisms of older children and subscribes to the group code, even when it runs sharply counter to his own, his family's, and the school's.

At these ages boys and girls begin, for a while, to go their separate ways, partly because their traditions and abilities diverge, partly because the same-sex peer group decrees contempt for the other sex, and perhaps partly as a defense against sexuality. The girl's peer culture is in general closer than the boy's to adult values.

Throughout this period children continue to love their parents, but shun public manifestations of affection. Their love alternates with a shrewd skepticism, and they are quick to protest either babying or apparent injustice. The war cry is, "It's not fair!" An excess of scheduled activity and adult direction in out-of-school hours can smother the natural childhood-centered life of children.

In school the child must cope with a whole new realm of abstractions—of words and letters and numbers, and, increasingly, of general facts and important principles. He has a voracious curiosity; he can absorb and retain quantities of knowledge; but he still finds difficulty in organizing and combining what he learns. Obviously, good teaching can help him in this direction.

How well the child can assimilate school learning also depends on the richness and variety of his earlier experience, on the values his family attaches to learning, and on his family's use of the printed word and other symbols. The things to which children are exposed before they reach school age have changed radically in recent years, partly because of the mobility of families today and partly because of such media as television.

Some investigators have suggested that we will have to revise certain of our ideas about learning readiness. Children can probably learn a lot more than we give them credit for, if only we can find the right kinds of challenges. Education has still to investigate and apply both the theory of "critical periods"—the notion that there may be optimal times for certain kinds of learning—and the concept of "learning to learn," which suggests a kind of interfacilitation among learnings even when these are not directly related.

The most skillfully devised curricula and teaching techniques can never be an adequate substitute for the wise, mature, stable, well-informed teacher who can spark her pupils' curiosity and release their energy; who can work with them rather than on them or against them, and who can, without intruding, help children in all areas of learning, including the learning of social relationships.

In summary, the early school years are a time of directness and innocence, of anxiety, literalism, moralism, "magicalism," superstition, and rigidity.

But they are also the years in which the foundations of the child's mastery of reality are being laid, and in which he is learning to deal with people in ways that will serve him all his life.

JOSEPH CHURCH and L. JOSEPH STONE
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# PRE-ADOLESCENCE

THE 9- OR 10-YEAR-OLD is in one of life's most stable periods, emotionally and physiologically. He has grown into his body proportions—although he will soon grow out of them. He is self-possessed, competent, energetic, enthusiastic, and clearheaded. He has outgrown many of the anxieties and rigidities of the beginning school years, and it is only at the approach of adolescence that he will have to begin wrestling with problems of identity, values, sexuality, jobs, and adult responsibility.

Ages 8 to 11, perhaps, are the years in which the child is most wholly a child, looking neither back nor forward but content to be what he is, a player both of ritualistic and of competitive games, a skillful bike rider and swimmer, a boisterous attendant at Saturday movie matinees, an insatiable glutton, a talker of pig Latin and a writer of codes, a shunner of bathtubs, a master of bland guile, an adventurer. But if the child enters pre-adolescence dirty, he leaves it clean; he enters it self-assured and leaves it self-conscious; he enters it a child and leaves it as the in-between creature, an adolescent.

There are marked differences between the behavior of the sexes in these years, as a visit to any junior high school will attest. By the age 10 or 11, about half of the girls have begun blossoming into young ladies, while the boys are still high pitched and rowdy. Recently, however, change has come over the behavior of children in the middle and late school years—a decided acceleration of social development. This is exemplified by dating (and even going steady), by dandyism in boys, and by lipstick, nylons, and high heels for girls, even as young as 9. Along with this acceleration goes an unprecedented "maturity"—or semblance of maturity. This new pseudomaturity may seem to simplify some of the problems of adolescence and young adulthood, but there is real danger that it may obstruct growth into genuine maturity. Children who go through this forcing process may be missing out on the real joys of childhood.

The late school years are the age when high spirits, defiance of adults, and an urge to try oneself out may spill over into vandalism, delinquency, and violence. Now the term "gang" may take on sinister connotations. Whether or not this happens depends a great deal on the neighborhood and its values and institutions. Vital, too, are relationships with parents: present relationships that may drive a child into delinquency as a protest against neglect, indifference, or hostility; and earlier relationships, that did or did not make for a sense of identity and the development of a conscience.

In this period, the conscience is not fully developed and therefore not wholly dependable. Hopefully, it is flexible enough to allow the child to experiment, even in ways that may seem unwholesome to adults, but solid enough to stop him short of behavior harmful to himself or others. Parents can still reinforce a child's conscience, but it is too late to start instilling one.

The "halcyon days" of childhood used to represent an area of freedom bounded by adult authority and values. Nowadays, the child's childhood is more ambiguous and so are the authority and values of his parents. Many parents no longer feel sure of their values, and many others hesitate to assert their own values, especially when they fear that to do so might make their child "unpopular." Childhood has been cut short by pressure to be an adolescent quickly, by the garishly glamorous role we have given the teenager, by the irrelevant intrusion of adults into areas that used to belong to the child, and by adults' abdication of areas that used to belong to them.

JOSEPH CHURCH and L. JOSEPH STONE

# EARLY ADOLESCENCE

NEARLY ALL HUMAN BEINGS go through essentially the same pattern and sequence of body growth. But individuals vary greatly in the rate at which they move through this patterned sequence. Girls who reach physical maturity early may enter adolescence by the age of 10, while girls who are late in maturing may not truly become adolescents until they are past 16; the average age is around 13. For boys, the earliest to mature begin adolescence before age 11, the average begin adolescence at about 14, and the latest at about 17.

Major developmental tasks associated with physical growth during early adolescence include: learning to manage a rapidly growing body, learning to accept the kind of physique that comes with reproductive maturity, and learning to understand and manage the new concerns about body functions that emerge with full gonadal development.

In our society, the activities, customs, and codes of peer groups in early adolescence vary markedly from those of preadolescence. Consequently, learning the skills and customs required for early adolescent peer-group participation is a major developmental task. The need to belong is so strong at this stage that conformity to peer-group customs and codes is a compelling motivation.

Especially important in early adolescence is the learning of sex-appropriate skills in grooming, in games, and in social behavior to accord with peer-group standards. Equally significant is learning how to interact with peers of the opposite sex so as to win prestige with them.

With the experience of organic maturing, children tend to seek greater freedom to decide upon their own behavior.

These youngsters need the love of parents, siblings, peers, teachers, and other adults important to them as a basis for emotional security while working at their difficult developmental tasks. Unfortunately, withdrawal of affection is often used as a means of punishing them or of pressing them into social conformity. The consequent emotional insecurity may give rise to hostility or to self-doubt.

Early adolescence is the time, in our culture, when choices are made at home and at school which markedly limit or broaden the vocational, social, and recreational activities that will be open to the individual during adult life.

Research concerning the growth of intelligence suggests that the potential for giftedness occurs with considerable frequency in all social classes and in all racial and ethnic groups in our country. Physical and social environments that impoverish the experience of children and youth seem to result in progressively lower scores on intelligence tests for early adolescents living under these conditions. In contrast, youths from experientially rich and stimulating environments seem to achieve progressively higher scores and to grow in capacity during a longer period.

Available evidence does not support the conclusion that early adolescence is necessarily a time of great emotional stress for either boys or girls. The amount of anxiety, inner conflict, and emotional stress seems to depend rather upon the degree to which the individual is successful in accomplishing the developmental tasks peculiar to his or her maturity level and in meeting the expectancies and demands of home, school, and other social institutions in which he or she is playing roles.

The younger adolescent's concept of himself—the way he sees himself, the way he feels about himself in his world—seems to be influenced by a considerable number of factors. These include: his physical attractiveness and grooming; his organic health and vigor or organic inadequacies; his skill in managing his body; emotional security or insecurity based upon the climate of love in which he lives; the richness or meagerness of his background of experience; the racial, ethnic, and social class cultures he has internalized; the roles and status he has achieved in his peer group; the adequacy with which he has met the expectancies and demands of home, school, and other institutions; the kinds of adjustment mechanisms he habitually uses. In turn, the way he sees himself in relation to the world profoundly influences the meaning he perceives in each specific current situation and, consequently, his behavior in that situation.

Children in early adolescence tend to vary more widely in each characteristic significant for their learning and adjustment than do younger children. For this reason, persons and institutions responsible for working with them can make valid judgments about their motivations and needs *only* on the basis of extensive and accurate information about *individual* boys and girls.

DANIEL A. PRESCOTT
*Director, Institute of Child Study*
*University of Maryland.*

# LATER ADOLESCENCE

THE OLDER ADOLESCENT'S concept of himself, the way he sees himself in his world, is shaped by the same constellation of factors that influences the younger adolescent—in short, the climate of love and expectancy in which he lives and his skill in living up to his own and others' expectations of him.

These factors are causally related to the success or failure each individual has had in accomplishing his early-adolescent developmental tasks. How he feels about himself and the world he knows depends

greatly upon whether or not he perceives himself as having successfully resolved these earlier developmental tasks. If he sees himself as having failed to meet them adequately, then adjustment mechanisms emerge and either withdrawal or compensatory activities arise. A developmental task not accomplished in the appropriate period of life remains a troublesome adjustment problem later.

But the youth in late adolescence faces new developmental tasks, evoked by his awareness of his own maturing in the context of the expectancies and demands of his family and of society. Especially significant among these is choosing, preparing for, and, in some instances, entering a vocation. He needs to learn what vocational opportunities exist for a person of his capacities, characteristics, and aptitudes; to explore what it is really like to engage in possible vocations; to ascertain the ways one can prepare for them; to know himself well enough to make a wise choice; and to plan and take the necessary steps to prepare for the chosen vocational activity.

Scant help is afforded today to most older adolescents in this quest for a vocational role; indeed, many blocks are thrown in their way when it comes to tryout and training experiences on the job.

Sensing his approach toward adult roles and responsibilities, the older adolescent usually asks himself what he really values and what he really believes in. For years he has been expected to (and usually does) accept the teachings of home, school, church, and significant adults as true indicators of reality. Some are content to continue in this pattern. But many, discerning a marked discrepancy between the precepts usually expressed by adults and actual operations in government, business, education, and personal living, repeatedly ask themselves and their peers (in effect): "What is there to really believe in?" "What is worth effort, sacrifice, and risk in the world we know?" "By what dedication, if any, can I fulfill my need for significance?"

Obviously the answers arrived at by boys and girls in late adolescence depend upon their cumulative perceptions of the world and of the "successful" people of our society.

Research has shown that older adolescents' concepts of God, heaven, the purpose of prayer, and the possibility of immortality are distinctly different from those held by 12- to 15-year-olds. The implication is that the youth in his late teens is seeking his own orientation in the universe and eternity, as well as struggling to crystallize a set of values and a moral code by which to live in the world he is discovering. Consequently, religious beliefs are generally reexamined and often altered during later adolescence.

Developing the skills required for successful courtship and exploring the problem of choosing a marriage partner also preoccupy these young people. Prevailing myths about romantic love, the stirring sensations accompanying pre-coital sexual explorations, stressful personal relationships at home, and the lack of clear-cut teaching about what love really is leave many older adolescents confused about what constitutes a satisfactory interpersonal basis for a stable and happy marriage.

A pervading sense of anxiety among the older teenagers has been discerned and described by many persons studying or working with this age group. It is an anxiety related to directionlessness. The widespread geographic mobility of families has robbed many young people of roots of any depth in any particular community. The cold war, the threat of damage to the human race by atomic fallout and of annihilation by atomic warfare, and the lack of any generally accepted sense of national purpose to move toward some cherished goal may help to account for it. Boys face the additional stress of being drafted for military service. Even more disturbing could be the extreme scarcity of activities having genuine social usefulness which older adolescents can undertake as natural and generally valued steps toward assuming full adult responsibilities.

DANIEL A. PRESCOTT

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Boys and girls are not delivered as raw materials at the school door. They are already products—products of five or six years of processing in their homes. More and more, we realize that what the school can do to develop a child's potential is limited by what the home has already done, and is doing, to him and for him.

*Mrs. James C. Parker, President, National Congress of Parents and Teachers*

# HERE AND THERE

## *Report to Congress on Juvenile Delinquency*

"The factors related to the occurrence of juvenile delinquency are so numerous and complex that only extremely well-coordinated approaches utilizing all of the governmental and nongovernmental resources of our society—local, State, and national—can hope to be effective in curbing the present trend."

This is one of the eight major findings contained in a joint report on juvenile delinquency prepared by the National Institute of Mental Health and the Children's Bureau and presented to the Congress late in February by the Secretary of Health, Education, and Welfare. The other findings in brief are:

- Both the rate of delinquency and the numbers of delinquents are rising.
- While most prevalent in deteriorated sections of large cities, delinquency's most rapid rate of increase is in small towns and rural areas.
- While more of the kinds of services now offered to rehabilitate delinquents are needed, new approaches, techniques, and methods for dealing with delinquents are needed even more.
- While there are some hopeful leads to the prediction of delinquency in children and techniques of prevention, these are "still to be developed" as useful tools.
- Today's preventive and treatment services are impeded by lack of coordination, personnel shortages, and inadequate financing.
- Research, field and pilot studies, and demonstration projects are needed for finding effective ways of dealing with juvenile delinquency.
- The organization, coordination, and staffing of agencies having responsibility for dealing with the problems of delinquency need strengthening.

The report suggests that the Federal Government, through a number of its administrative departments, can play a leadership role in solution of the delinquency problem. It specifically recommends two major parts for the Department of Health, Education, and Welfare: (1) increasing its support of research, field and pilot studies, and demonstration projects concerned with the causes of, and techniques of preventing and dealing with, delinquency; and (2) helping to alleviate the shortage of adequately trained personnel through: (a) studies of methods for incorporating knowledge from the behavioral, social, and psychiatric sciences into the training of those who deal directly with delinquents; and (b) the "pilot development" of content of training "to increase the ability" of psychiatrists, psychologists, and social scientists "to make contributions in the field of juvenile delinquency."

### *Summary of Studies*

The body of the report summarizes the results of 8 months of fact- and opinion-gathering by the two agencies, charged last year by the Appropriations Committees of both Houses of Congress with studying and reporting on the problem of juvenile delinquency. (See CHILDREN, November-December 1959, page 235.) It is supplemented by 10 volumes of supporting documents.

Beginning with a definition of juvenile delinquency as "acts by children of a specific age range—acts forbidden by law," the report points to the importance of differentiating between delinquency and "the ever-recurring nonconformity of youth." It suggests, however, that "some behaviors of children that do not constitute delinquency" are "warning signals" which must be dealt with in any consideration of the problem.

The report refers to statistics showing that the rate of delinquency reported from juvenile courts doubled in the decade between 1948 and 1958, and suggests a parallel to this in the rise of juvenile delinquency in the 1920's "when some features of our society resembled some of those of today." It points out that since World War II outbreaks of juvenile delinquency have occurred in many of the countries of the world.

After reminders that "knowledge of causes does not always result in ability to control a problem" and, conversely, that control is "not always completely dependent upon full understanding of causation" the report discusses the social and psychological factors "related" to delinquency. High delinquency areas, it says, are characterized not only by physical deterioration but by heterogeneous moral standards, lack of neighborhood solidarity, lack of opportunities for youth, and the presence of "successful" members of the underworld.

"Children learn from what they see around them, not merely from what they are told," says the report, referring to sociological theories of delinquent subcultures. These it describes as reactions of youth in low-income areas to the feeling of being disadvantaged in the competition for social success and material wealth and to their awareness of "the prevalence of illegal activities and departures from morality" that occur in the larger society.

The report also refers to psychological pathologies as productive of delinquency, pointing out that while these occur in any type of neighborhood, "the conditions of family life in underprivileged areas operate to increase the probability of psychological disorder among children." Children expressing psychological disturbance through delinquent behavior may be able to recruit other children to such behavior, it suggests. But it adds that "the problem of delinquency cannot be approached only, or even primarily, through the individual delinquent."

### *Methods of Control*

In discussing ways in which delinquency might be reduced, the report suggests two points of attack: (1) individual or group treatment of delinquents or "those verging on delinquency" and their parents; and (2) changing those aspects of all children's environment thought to be conducive to delinquency. It points out that studies to evaluate the effectiveness of clinical treatment have been "inconclusive" and warns against exclusive reliance on clinical methods. It suggests, however, that the apparent ineffectiveness of some attempts at clinical treatment of delinquents may be due to the absence either of "appropriate conditions for therapeutic contact" or of needed health, educational, recreational, or vocational services.

While the report states that the first

symptoms of delinquency often appear in early childhood, it enumerates various problems besetting efforts to develop techniques for identifying "predelinquents" and warns that stigmatizing a child by mistaken identification may in itself lead to delinquency.

The report suggests a "promising plan" for a community program of delinquency control embracing three approaches: (1) an integration of the community clinical and treatment facilities for children with behavior problems; (2) the stimulation of concern for such children on the part of the schools, the churches, recreational facilities, employment services, and other "nontreatment agencies"; (3) an organized "arm for reaching out" into high delinquency areas through groupwork with street corner gangs and through aggressive casework with multiproblem families. Underscored as important in these efforts are vocational counseling and work-study programs to help young people in the transition from school to work, and the use of the school system for detecting signs of potential delinquency and providing remedial counseling and other specialized services through school social workers and guidance personnel.

Calling the "absence of systematic research" one of the most serious problems in relation to delinquency, the report discusses the difficulties inherent in longitudinal studies. It advocates analysis of delinquency data developed by other countries, especially in relation to the effects of urbanization, industrialization, social mobility, changes in family structure, and economic patterns. It also advocates research relating to social roles, to the way young people bridge the gaps between childhood and adulthood, and to the effects on personality of the ways families transmit cultural values; and "action research" projects integrating basic research and its application.

The "single most important fact about delinquency," according to the report, is that it includes "a wide variety of behaviors as well as a wide diversity of contributing factors." The report puts the chief responsibility for prevention on "the social institutions through which children are reared and prepared" for life, including the family, church, school, and neighborhood. These, it maintains, are in turn largely dependent on the character of society's values and goals and on the correspondence between these and the means provided for achieving them.

The report, entitled "Report to the Congress on Juvenile Delinquency," is available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C. (Price 35 cents.)

## *WHC Publications*

Three additional volumes of materials, published by the 1960 White House Conference on Children and Youth, came off the press in mid-March and were distributed to the 7,600 Conference participants. They include: "Children and Youth in the 1960's," a collection of papers surveying each of the major themes of the Conference (340 pages, $2); "Focus on Children and Youth," a report of the Council of National Organizations on Children and Youth on the major points made in reports submitted by its affiliated organizations (355 pages, $1.50); and "The States Report on Children and Youth," a summary of the concerns and recommendations contained in the States' reports to the Conference (232 pages, $1.50).

Two other volumes were put on sale at the Conference: "Reference Papers on Children and Youth," a collection of technical papers (294 pages, $1.50); and "Information Sheets on Children and Youth," a compilation of all the fact sheets prepared for the 210 workgroups of the Conference (302 pages, $1.25). All the volumes may be ordered through the Conference (330 Independence Avenue, Washington 25, D.C.), with the addition of a 25 cents charge for mailing.

The survey papers, grouped under five headings—The Current Scene, Beliefs and Values, Services, Special Problems, and Community Action—discuss among other subjects: suburban living; religious development; health, education, employment, and leisure-time services to children and youth; minority-group status; migrant families; family disorganization; children and young people who are physically handicapped, retarded, disturbed, or delinquent; and human resources for services to children and youth.

"The States Report on Children and Youth" describes the "grassroots activities" in gathering the material for the reports, evidences of progress in meeting various needs of children during the past decade, and major current problems.

The report of the national organizations focuses on the changing scene affecting children's social and economic welfare, education, health, religious heritage, intergroup relations, vocational opportunities, and leisure-time activities, from the point of view of agencies serving these interests. Chapters are also devoted to children with special problems—the ethnic and racial minorities, the mentally retarded, and the emotionally disturbed.

The technical papers in the reference volume contain theoretical presentations on the effects of social and cultural practices on personality development and some statistically documented reports on specific social and health problems, including among others racial discrimination, lack of employment opportunities, school leaving, accidents, allergies, delinquency, drug addiction, and pornography.

Other materials available from the Conference are three volumes of background papers entitled "The Nation's Children" (price $6), and a chart book, "Children in a Changing World" (price $1.25). See CHILDREN, March–April 1960, page 77.

## *New UNICEF Services*

Four UNICEF social service projects, the first of their kind under a program authorized by the Executive Board of the United Nations Children's Fund in 1959, were approved by the Board at its March 1960 meeting. Under the projects, to be carried out in cooperation with the U.N. Bureau of Social Affairs, UNICEF aid will be provided to Guatemala, Uganda, Turkey, and the United Arab Republic (Egypt) for improving social services to children needing care outside their own homes. All four projects will emphasize the training of child-care personnel.

The aid will be in the form of teaching aids such as audiovisual equipment for use in the training of personnel, motor vehicles for use in supervision and training, playground equipment, and in some instances salaries for teaching staff and stipends for trainees. The total amount of UNICEF funds involved in the four projects will come to $110,500.

The four recipient governments have agreed to undertake the strengthening and coordination of their social services,

to develop inservice and special training courses, to improve existing day-care and community centers, to survey social needs, and to add whatever protective legislation need indicates.

In addition to the four social service projects the UNICEF's Executive Board approved projects to aid mothercraft and homecraft activities in Morocco, Tanganyika, and Uganda. The aid, to be given in the form of teaching and training equipment, stipends for trainees, and transportation, is designed to complement or prepare for the development of social services for children.

For the past year the United Nations has had a special child-welfare consultant in its Bureau of Social Affairs, helping interested governments plan the development of their social service programs, with UNICEF assistance.

## *Public Housing*

Through a Joint Committee on Housing and Welfare the National Social Welfare Assembly and the National Association of Housing and Redevelopment Officials recently developed a set of fundamental principles for public housing rentals for families receiving public assistance. Among them are: That families receiving public assistance and other low-income families should have equal access to public housing; that localities should obtain the full annual Federal contribution for housing authorized by law; that rentals for families receiving public assistance should be based on full operating costs; that such rentals should be set on a citywide rather than a project basis; that public assistance families should not be discriminated against in tenant selection; that public housing and public welfare officials should join in making sure that the maximum social benefits are obtained by the families from the housing and public welfare programs.

A subcommittee of the joint committee, after a year's observation of a local housing authority which had run into serious difficulties, has drafted a discussion outline of principles to guide initiation and administration of a public housing program. Emphasizing the broad social implications of such programs, the statement maintains, among other points, that housing authority commissioners should be selected largely on their ability to understand community problems and relationships, that project managers should possess a social philosophy consistent with a housing authority's purpose, and that social agencies should help to bring such officials and the whole community an understanding of the social factors involved in a housing program.

The statement also declares that the housing authority should see that social work skills be made available to project residents, at least through referral to appropriate agencies, and that social agencies should unite to focus on problems related to housing and should join with housing authorities in helping to prevent family breakdown in housing projects.

It suggests that the authorities avoid concentrating identifiable minorities or families with serious social handicaps in specific projects thus tending to isolate them from the general community. It also urges public assistance agencies and housing authorities to develop a good working relationship.

Copies of both statements are available from the National Social Welfare Assembly, 345 East 46th Street, New York 17, and the National Association of Housing and Redevelopment Officials, 815 17th Street NW, Washington 6, D.C.

## *Nutrition*

A mixture known as Incaparina has proved satisfactory as a source of protein for young children in field trials over a 4-month period in several rural communities in the highlands and lowlands of Central America, according to a report from the Institute of Nutrition of Central America and Panama (INCAP). The product is the result of several years of effort by INCAP to develop a mixture of native vegetable products that in combination would compare favorably with milk in protein value. The purpose is to combat protein malnutrition, a major cause of illness and death among preschool children in some tropical areas where cow's milk is not readily available and supplies of other animal proteins of high nutritional value, such as meat, fish, and eggs, are scarce. According to the report, the trials showed that mothers liked the supplement because it was easy to prepare and that children took it readily and made satisfactory progress.

Incaparina has since been offered for sale in another community at a cost of 3 cents for a package for one day's supplementation. Purchases have been encouraging. Consideration is being given to commercial production of the supplement in Nicaragua, El Salvador, and Guatemala.

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Japanese children in elementary and secondary schools today are much healthier than their prewar counterparts, according to a report from the Japanese Government. They have better health habits, are freer of colds, have greater immunity from the common diseases of children and have shown greater growth in height, weight, and girth. The report credits some of the improvement to the provision of school lunches, which were introduced in 1947. The foods served include bread made of enriched flour, powdered milk, fish, meat, eggs, soybeans, potatoes, other vegetables, and fruit. Formerly the children's diet, as well as that of adults, consisted mainly of rice.

## *School Health*

The Committee on School Health of the American Academy of Pediatrics recently issued a report on school health policies, recommending three types of services for a health program for school-age children. These are: (1) routine, regular physical examinations, preferably before the child enters school, again during the intermediate grades, then at entrance to secondary school, and finally before completion of the secondary grades; (2) followup of each examination with medical supervision when any abnormality is found; and (3) education and counseling of parents in need of following medical advice concerning their children's health. Identifying roles in such a program for school boards, parents, teachers, nurses, and private and school physicians, the Committee recommends that school physicians serve primarily as health advisers rather than sources of medical care.

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Booklets for keeping a child's individual health record from birth through his 17th year are now being provided to parents of newborn babies by the Colorado State Department of Public Health. The booklets contain spaces to be filled in over the years with information showing: steps in early development; growth in height and weight; medical examinations, including date, results, recommendations, and name of

doctor; special examinations and tests; immunizations; allergies; illnesses; operations; hospitalizations. Spaces are also included for the mother's medical record in connection with the child's birth. The health record was prepared by the department's maternal and child health section, with the approval and help of the State medical society and the State congress of parents and teachers. It was developed not only as a method of recording health information but also to encourage periodic health appraisal of children.

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Maximum use of existing community facilities for helping handicapped children is sought by a committee operating a 3-year project to coordinate the services available in Summit County (Akron), Ohio. The project, now in its second year, is financed by Children's Bureau, State, and foundation funds. Six cooperating health agencies work with the committee: a rehabilitation center, a society for crippled children, a council for the mentally retarded, the district heart association, and United Cerebral Palsy.

The project's activities include: carrying on a clearinghouse on services available to physically or mentally handicapped children; developing panels of consultants for recommendations on multiproblem cases; working to obtain casework and groupwork for handicapped children; providing consultation to the cooperating agencies on program aspects of work with handicapped children and on administrative problems; increasing community understanding of the problems of the handicapped and of programs for them.

The project has an advisory committee representing the six cooperating agencies and community groups.

## *Child Welfare*

Four national voluntary social-welfare organiaztions the Child Welfare League of America, the Family Service Association of America, the National Probation and Parole Association, and the National Travelers Aid Association have joined in establishing a program to help States and communities to review their services to children and families and to find ways to coordinate and improve them.

The new "joint survey service," which began operation April 1, 1960, makes available for community surveys the combined knowledge of a battery of professional workers—staff members of the four national organizations—trained and experienced in the four fields with which these organizations are concerned: care of needy, neglected, or dependent children; family counseling for marital and parent-child problems; probation and parole services for juvenile delinquents and youthful offenders; services to travelers, newcomers, and migrants. Its purpose is to provide comprehensive appraisals of the various needs for casework services in local communities; to facilitate the promotion in communities of sound casework services and a balance of related social and health services; and, incidentally, to bring the four national associations closer together for exchange of information, examination of policies, and promotion of high standards of service to meet the needs of troubled people.

The new service is working closely with the National Social Welfare Assembly and the United Community Funds and Councils of America. Its director is Maurice O. Hunt; its address, the headquarters of the Family Service Association of America, 215 Park Avenue South, New York 3. Fees for surveys will be charged on the basis of costs.

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An experiment in applying some of the insights of family-centered casework in a program of foster-family care for emotionally disturbed children is being carried on in a 9-month demonstration by the Division of Child Welfare of the Minnesota Department of Public Welfare. In this experiment, the focus has been widened to include the foster family as a whole rather than concentrating solely on the foster child. Its purpose is to achieve a collaborative assessment, by social workers and psychiatrists, of the realities and potentialities of foster care as the resource of choice for seriously disturbed children.

Three psychiatrists are devoting a minimum of 56 hours a month to the project. They, as well as the social workers, visit the foster-family homes in an effort to get a picture of family interaction and relationships and to involve the foster parents more closely in the child's treatment. In general the social worker rather than the psychiatrist carries the responsibility in the treatment team, though this varies with the circumstances. One psychologist is available to give tests and to confer with the other project workers.

Each member of the team is evaluating the potentialities of the foster family separately after several interviews with the child and the family. At the end of the project each will again evaluate the effects of this approach on the family and the child. The hope is to learn something about the likelihood of response to various treatment measures, what kinds of problems can be anticipated, which children should not be in foster-family placement, and the kind of care they need.

## *Attacking Dependency*

A coordinated effort to change conditions leading to family breakdown and dependency has been urged for the city of Washington by a committee of the District of Columbia Health and Welfare Council as a result of a study of the reasons for the rising population of the District's institution for dependent children. Maintaining that the effort must be carried out not only by governmental and voluntary agencies but also by citizen action the committee sees it as involving improvements in housing, employment opportunities, community education, and juvenile court procedure.

The institution, Junior Village, in 1947 housed 30 children; in 1958 it housed 302—a 900 percent increase. Since Washington's population was not growing at any such pace during those years, the committee points to the figures as a sign of multiplying family dependency in the city.

Some of the recommendations for measures aimed to get at the roots of family dependency include: adult education to improve family living; revision of the unemployment compensation program; promotion of employment opportunities for young people, with special attention to eliminating racial bias in hiring; action toward fulfilling the housing needs of low-income families, including enforcement of the present housing code.

Recommendations concerning the work of the Department of Public Welfare call for an enlargement of staff in order to provide more professional time for helping families and children in crises; an expanded staff development

program; improved casework methods for helping families stay together; more coordination of public assistance and child welfare services; reexamination of use of resources for care of children and expansion of the foster-family home program; and changes in laws and regulations that "distort the proper execution of the Department's function," so that the primary consideration in assisting children will be their need.

Recommendations applying to the juvenile court include: increase in the probation staff; addition of two judges; and consideration of reconstituting the court as part of a family court.

The committee also recommends that a planned neighborhood-by-neighborhood attack be made to prevent family breakdown and dependency, using every community resource—every public agency, civic and fraternal organization, church, labor union, business—to reach out to help families endangered by failures in employment, housing, education, recreation, health, or the basic tenets in family living.

The committee has published its findings in a report, "What Price Dependency?"

# IN THE JOURNALS

## *Alien Children*

In a symposium of "The Alien Child," published in *Social Casework* for March 1960, three New York social workers call attention to the special problems and anxieties of families that have immigrated to this country.

Discussing the alien child living with his own family, Harold B. Sharkey of Jewish Family Service points to the overlapping of the child's problems with those of the other members of his family and to the effect on the child when the parents compound his problems by using him as a repository for their own anxieties.

Gladys Weinberg of the Jewish Child Care Association, describes how her agency helped an alien 10-year-old boy whose bizzare behavior made it necessary for him to live away from his family, and worked to lessen the guilt feeling of his parents, who could not believe it was right for them to let the boy be placed in a foster family.

The difficulties of children from abroad who are adopted in the United States are described by Eugenie Hochfeld of the American branch of International Social Service, who emphasizes that the inevitable risks can be held to a minimum when social welfare agencies offer appropriate service.

## *Mentally Ill Adolescents*

If adolescents in general need more recognition and security than any other age group, the mentally ill adolescent has an even greater need for them, says Kathleen Bueker in the *American Journal of Nursing*, March 1960. ("Adolescents Need Attention.") The author, who is clinical instructor in psychiatric nursing at St. Elizabeths Hospital, Washington, D.C., describes successful efforts of nursing staff to treat understandingly a group of mentally ill adolescent girls and in spite of some violent behavior—kicking, fighting, cursing—to achieve consistency in providing guidance, discipline, and psychological support.

## *Group Consultation*

Two articles in the March 1960 issue of *Child Welfare* describe an experiment in the use of a psychiatrist to give group consultation to staff members of a maternity home to help them understand their own feelings and behavior in order better to be able to understand and help their patients. ("Psychiatric Consultation With Staff of a Maternity Home," by James T. Thickstun, M.D., and "Consultation in a Maternity Home; the administration's point of view," by Sr. Capt. Vivian K. Johnson, administrator, the Salvation Army Booth Memorial Hospital, Los Angeles.)

The psychiatrist, Dr. Thickstun, discusses how the emotional problems and interrelationships of staff members in this type of setting affect the workers' behavior with patients and the methods he found effective in helping members of the group to clarify their thinking. More important than techniques, he found, was providing the atmosphere conducive to self-observation and the stimulation of change.

Captain Johnson discusses the effects of the program on the staff, beginning with a large measure of hostility to program and psychiatrist and developing into a "team approach to all problems, with increasing insight into the patients' needs." "The staff no longer wanted to get rid of the unruly, hard to handle, psychotic, or acting-out unmarried mother," she notes, and adds, "all concerned gave evidence of their ability to grow and develop under the impact of the program."

## *New Journals*

Among the new journals which made their appearance at the beginning of 1960 are: *Rehabilitation Record*, published by the Office of Vocational Rehabilitation, Department of Health, Education, and Welfare—first issue, January–February 1960 ($1.75 a year; single copies 30 cents); *The Journal of Intergroup Relations*, published quarterly by the National Association of Intergroup Relations Officials, 426 West 58th Street, New York 19, first issue winter 1959-60 ($6 a year; single copy $1.75); *The American Journal of Catholic Youth Work*, published three times a year by the Youth Department, National Catholic Welfare Conference, 1312 Massachusetts Avenue, NW, Washington 5, D.C., first issue winter 1960 ($5 a year; single copy $1.50); *Journal of Health and Human Behavior*, published quarterly by the Leo Potishman Foundation at Texas Christian University, Fort Worth 29, Tex., first issue spring 1960 ($6 a year for institutional subscribers; $4 for individuals).

## *Public Welfare Report*

The January 1960 issue of *Public Welfare*, the quarterly journal of the American Public Welfare Association, presents a report of the association's National Biennial Round Table Conference, held in Washington, D.C., December 2–5, 1959.

# BOOK NOTES

A GENETIC FIELD THEORY OF EGO FORMATION: its implications for pathology. René A. Spitz. International Universities Press, New York. 1959. 123 pp. $3.

The author of this book describes three developmental stages occurring in the first 18 months of life. The first is indicated at about 3 months by the infant's smiling response, the second at 6 to 10 months by his recognition of individuals, and the third at about 18 months by his acquisition of speech. An abnormality at any of those "critical periods," the author says, will influence the next one unfavorably.

Describing the three stages as "the prehuman steps on the road to humanization," the author points out that he does not consider his propositions the ultimate formulation of the laws of psychological development, but as helps in understanding such development, which may serve as hints for later therapeutic procedure.

The author, is at present visiting clinical professor of psychiatry at the University of Colorado.

NORMAL CHILDREN AND MOTHERS: their emotional opportunities and obstacles. Irving D. Harris. The Free Press, Glencoe, Ill. 1959. 287 pp. $6.

A study of normality in children, made as a step toward better guidance of mothers and children, is reported in this book by a psychiatrist on the staff of the Illinois Institute for Juvenile Research. In the study 54 children 8 and 9 years old, described by school personnel as "normal," were given a variety of diagnostic tests and interviews by a team consisting of a psychiatrist, a psychologist, and a social worker. The children's mothers were similarly studied.

Agreeing with the opinion of the school workers that all the children were within the limits of normality, the team found 25 children "very well adjusted," 11 "well adjusted," and 18 "fairly well adjusted." The team found that the degree of normality of the children seemed to be intimately related to the emotional maturation of the mother.

The book includes 54 short "profiles," noting for each child the school report on his adjustment in his latency and puberty periods, his relationship with the psychiatrist, his play activity, and his dreams; and for each mother for her idea of the child's problem, the degree of impairment of her mothering qualities, her ability to relate to the interviewer, and her dreams.

In a chapter called "Implications" the author notes that "the inevitable presence of abnormal potential" in a person is not so pertinent to his mental health as the "interrelationship between the abnormal and normal potential."

THE PSYCHOANALYTIC STUDY OF THE CHILD, vol. 14. Edited by Ruth S. Eissler, Anna Freud, Heinz Hartmann, Marianne Kris. International Universities Press, New York. 1959. 433 pp. $8.50.

The 17 papers included in this collection are divided into four groups, under the headings Theory, Research Projects, Clinical Papers, and Applied Psychoanalysis. Among the subjects treated are: play in relation to creative imagination, psychological processes in pregnancy, reversibility of results of material deprivation in infancy, and the nursery school as a diagnostic help to the child guidance clinic.

PREDICTING DELINQUENCY AND CRIME. Sheldon and Eleanor Glueck. Harvard University Press, Cambridge, Mass. 1959. 283 pp. $6.50.

The purpose of this volume is to present "an entire *system* of predictive devices covering the span of years from first court appearance until approximately age 40, and including predictive devices for the early identification of potential delinquents." In it are brought together the various predictive scales worked out by the authors over a period of 30 years, with an account of their development and application, as well as definitions and directions for use. The authors express the hope that, despite the objections often raised against predictive devices in general, and the specific (and in their view unjustified) criticisms of theirs in particular, increasing use will be made of them by courts, parole authorities, and clinicians concerned with preventing and treating delinquency.

THE VANISHING ADOLESCENT. Edgar Z. Friedenberg. Introduction by David Riesman. Beacon Press, Boston. 1959. 144 pp. $2.95.

The fundamental task of adolescence—viewed as a social process—is clear and stable self-identification, according to the author of this book, a sociologist and teacher of adolescent development at Brooklyn College. Such identification, he maintains, is not being achieved by most adolescents today, partly because of our society's and especially the high school's emphasis on conformity and group adjustment.

Pointing out that the greatest safeguard to any democracy is a continuing community of self-respecting young people who understand and accept their relationship to society, the author maintains that "The basic unit of such a community is a stable self to respect."

THEY STEAL FOR LOVE: an experiment in education and psychiatry with children and parents. Anthony Weaver. International Universities Press, New York. 1959. 132 pp. $4.

This study of treatment of disturbed boys and girls in a small voluntary institution in England for children charged with delinquency traces the development of individual children's behavior in relation to their family backgrounds, and describes methods used in working with the children and their parents toward helping the child to adjust. The 17 children involved ranged in ages from 7 to 12. The author describes the institution's task as "to generate a discipline based on persuasion rather than force and to show the children, however hostile they might be, that we cared for them."

# READERS' EXCHANGE

**ERIKSON:** *A scientist who cares*

Professor Erik Erikson's great impact on our thinking seems to me to be the result of his truly seminal concepts, his deep understanding of the fusion of unconscious personality processes with overt cultural or social forces, and his ability to convey his meanings with a minimum of technical language. At the same time, his extensive audience among laymen almost inevitably gives rise to oversimplifications and some misunderstandings.

We are particularly appreciative of the point he made in the interview reported in the March–April 1960 issue of CHILDREN ["Youth and the Life Cycle," an interview with Erik H. Erikson] that the crises in each stage of the individual's life are not permanently conquered, but that the "healthy personality must reconquer them continuously in the same way that the body's metabolism resists decay." One of the most oversimplified and overworked words is "maturity," as if it were some goal which could be permanently maintained. As Professor Erikson points out, a residue of immaturity is carried throughout life and "a person moves up and down the scale of maturity."

We might add that attainable points in this scale are not the same for all people, but depend to some degree on the idiosyncratic genetic and social factors in the life history of an individual and on the society into which he is born. As Professor Erikson says, "Life is a sequence not only of developmental but also of accidental crises." We like, too, his point that the process of the adolescent's growth can be "a prime force in cultural rejuvenation," rather than a malaise to be "cured." Rapid social change need not be inimical to either the adolescent or to culture.

We are not too surprised that an organization devoted to problems of parenthood reprinted the author's original life cycle theory paper and omitted the last stage, Senescence: Integrity *vs.* Disgust. In our youth-centered culture parents seem so preoccupied with their children's growing up that they apparently forget that they might have problems in growing old. Obviously the two problems are related, as is the morality of young people with the morality of the adult world.

Professor Erikson notes that psychiatry has added very little to our understanding of morality, except by stating the dangers incurred in those moralistic attitudes which convince the child only of his parent's power rather than of his actual moral worth. Anthropology has also not made its potential contribution to our understanding of morality. The significant concept of cultural relativity has been so oversimplified by some anthropologists and by many laymen that it has tended to negate a deeper understanding of morality.

Professor Erikson seems to us to be a moral man, one who *cares* about man and his society. Perhaps only a moral person can come to grips scientifically with the problem of morality.

*Hortense Powdermaker,*
*Professor of Anthropology,*
*Queens College, New York.*

**VAN DER WAALS:** *Translations needed*

I am extremely interested in the study described by Dr. Paula van der Waals in her article, "Former Foster Children Reflect on Their Childhood." [CHILDREN, January–February 1960.] I am at present engaged in a similar though smaller followup study of young men and women who in their childhood were in foster care in Minnesota.

The van der Waals article is based on the 116 page Dutch publication "Oud-Pupillen Antwoorden," by Ida Alten. The fact that this is a study of former foster children in a different country whose experiences in the care of an agency took place years ago does not detract from its value to the present-day child welfare worker in this country. While great differences may exist between practice then and practice now, the long-time effect of foster care upon individuals can only be studied after the passage of years.

Furthermore, some of the problems upon which this study focuses attention are exactly those which remain with us in foster care today, as for example, the hazards to foster children of repeated replacements. This experience for foster children of today, as for the men and women who were foster children in Holland years ago, is likely to contribute to a feeling throughout life that they never "belonged." Nor are we yet sure that we know how to select foster parents who will truly meet the needs of children placed with them.

A follow-up study of this type presents many methodological obstacles, as well as difficulties in interpretation. The article mentions that although the interviews were based "on a rather elaborate questionnaire," the "interviewer did not produce this directly during her visits." It would seem extremely difficult to secure exactly comparable data unless exactly the same information was requested from each respondent, which could hardly be accomplished except within a highly structured situation.

Many of these former foster children had had experiences prior to placement which we would expect to have caused serious damage. This presents a problem in assessing the extent to which the current adult status can be attributed to the failure of foster care to meet the child's needs or to the traumatic pre-placement experiences.

The article points out that while "socially, many were rather well established . . . many felt unsuccessful, dissatisfied, and distressed. Emotionally unadjusted, they felt that their life had not been worth living"—a tragic state of affairs. Since the objectives of casework are to improve the individual's *social* productivity and to increase his *personal* satisfactions, it is highly appropriate for a followup study to examine both of these aspects of adjustment. But this, too, enormously increases the methodological problem and the problem of evaluating the findings. While there are rates of dependency, divorce, illegitimacy, criminality, and other indicators of social maladjustment among the general population against which these persons can be compared, there are no norms of well-being.

Tot Stenn should to be congratulated for undertaking this study of the consequences of its program and also for its intention to begin now to plan for another inquiry 30 years from now.

With all the loose money floating around for use for research, it is regrettable that some is not being used to translate this Dutch publication, as well as the similar Finnish publication of 1956, written by Reino Salo, "Kunnallinen Lastensuojeletyo Sosiaalisen Sopeutumisen Kasuattajana." The English summary, published in the Finnish volume, is helpful, but it would be good to see the full translation of both of these books.

*Elizabeth G. Meier*
*New York School of Social Work, Columbia University.*

SANDUSKY: *Problems from progress*

Over the last few decades there has been an interesting progression from the easier technique to the more difficult in serving the neglected child. Mrs. Sandusky's flash of perspective regarding this development reminds us that progress has an intriguing way of begetting new problems, requiring us constantly to adjust and refine efforts if our gains are to be held. ["Services to Neglected Children," by Annie Lee Sandusky, CHILDREN, January–February 1960.]

As Mrs. Sandusky mentions, the agencies that first became concerned with abused children functioned mainly as law enforcing instruments. If the complaint was abuse or neglect of the children, if the children were hungry while an inadequate father loafed, drank, or malingered, there was no need to enter upon intensive long-range family-strengthening efforts. The worker just vigorously waved the law at the father and had him put in jail or threatened to do so.

We have seen this approach recede into the past, superseded by a firm philosophy of helping the family to stay together. And now we are learning to get to the reluctant family, to help them to reach a point where they want help. This, of course, is an incomparably more difficult task, requiring consummate skill.

This development has not been accompanied by a commensurate public appreciation of the progress it represents. Thus we have another progress-begotten problem, as Mrs. Sandusky recognizes, when she mentions the need for fostering better understanding between the child welfare agency and other agencies such as the police.

The earlier procedure had an appealing simplicity. To see a jail sentence, or a threat of one, thrust at a neglectful or abusive parent was emotionally satisfying to an outraged public. But there is much less direct satisfaction for the public in the intangible, mysterious process of protracted casework without punitive features. The police officer, who works in a traditionally authoritarian setting and is perhaps the first to see the neglected child and his drunken parent, is apt to call for punitive action that will "protect the child against the parents." How tolerant will he be of the social worker who sees his job as being to help the child by the more tedious process of giving the parents an increased capacity to care for their family? Mrs. Sandusky is right in pointing out that where insufficient understanding impinges upon our work, mutual communication must be intensified.

Whatever we can do to extend our interpretative efforts to the public in general will make our work easier. But another point Mrs. Sandusky makes is perhaps even more important—that when our technique is understood and appreciated, then children are referred to us more freely. Here is a fact to be underscored by any agency that is contemplating any spurt of growth or improvement. Improvement of quality of service should be accompanied by improvement also in the agency's capacity for volume. If the agency is not prepared to meet the increased demand, the new burden will depress the quality of services, and the progress will have carried the seeds of its own betrayal.

*Paul W. Kerr*
*Director of Court Services, Hennepin County District Court, Minneapolis, Minn.*

# Guides and Reports

HOW RETARDED CHILDREN CAN BE HELPED. Evelyn Hart. Public Affairs Committee, 22 East 38th Street, New York 16. Public Affairs Pamphlet No. 288. 1959. 28 pp. 25 cents. Discounts on quantity orders.

Presents information about the mentally retarded and outlines the community services needed for their training and care.

THE SIGNIFICANCE OF THE FATHER. Family Service Association of America, 215 Park Avenue South, New York 3, 1959. 78 pp. $1.

Four papers dealing with the role of the father in the family and the effects of his absence, from the 1959 biennial meeting of the Family Service Association of America.

THE ONE-PARENT FAMILY. Anna W. M. Wolf and Lucille Stein. Public Affairs Committee, 22 East 38th Street, New York 16, and Child Study Association of America, 132 East 74th Street, New York 21, N.Y. Public Affairs Pamphlet No. 287. 1959. 28 pp. 25 cents. Discount on quantity orders.

Discusses problems of child rearing faced by parents who because of death, desertion, or divorce must rear their children alone. Not intended as a substitute for professional guidance.

THE PASTOR AND COMMUNITY RESOURCES. Charles F. Kemp. Published for the Department of Social Welfare, National Council of the Churches of Christ in the U.S.A., by the Bethany Press, Box 179, St. Louis 66, Mo. 1960. 96 pp. $1.50.

Includes: (1) basic principles underlying the pastor's relationship with social-work and other professional agencies; (2) information on agencies and other resources for helping people, grouped by categories of need; (3) a directory of national Government and voluntary resources; (4) blank spaces for addresses and telephone numbers of various types of local resources.

## SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

**Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.**

MATERNAL AND CHILD HEALTH SERVICES, 1957. Theodore Pritzker. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 53. 1959. 28 pp. Single copies free, from the Children's Bureau.

Compares 1956 and 1957 statistics on services provided or financially supported wholly or partly by maternal and child health sections of State and local health departments. Reports gains in special clinics for the mentally retarded (now available in 44 States), the number of mothers receiving prenatal clinic services (except dental treatment), and the number of children receiving most types of well child conference services, including immunizations (except against poliomyelitis).

JUVENILE DELINQUENCY—FACTS, FACETS: 1. The Children's Bureau and Juvenile Delinquency, Dorothy E. Bradbury, 73 pp., 30 cents; 2. Sociological Theories and Their Implications for Juvenile Delinquency, David J. Bordua, 22 pp., 15 cents; 3. Selected, Annotated Readings on Group Services in the Treatment and Control of Juvenile Delinquency, Mary E. Blake, 17 pp., 15 cents; 4. Delinquency Prevention—The Size of the Problem, I. Richard Perlman, 9 pp., 15 cents; 5. Identifying Potential Delinquents, Elizabeth Herzog, 6 pp., 10 cents; 6. Family Courts—An Urgent Need, Harriet L. Goldberg and William H. Sheridan, 14 pp., 15 cents. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1960.

These are the first six of a projected series of documents on juvenile delinquency addressed to a technical audience.

Number 1 presents the highlights of the Children's Bureau interest in juvenile delinquency since the Bureau's establishment in 1912, and includes an annotated bibliography of its published material relating to delinquency.

Number 2 reports on a Children's Bureau conference of sociologists, held to consider sociological theories on juvenile delinquency and their implications for future programs for prevention. The emphasis is on the causes of delinquency among the lower socioeconomic groups in the larger cities.

Number 3 lists annotated readings pertinent to the control of juvenile delinquency, selected primarily to help persons working with groups of delinquents in various settings.

Number 4 reviews evidence of increasing delinquent behavior in recent years and discusses briefly the handling of juvenile offenders by police and courts, undetected delinquencies, and research needed as a basis for preventing or reducing the problem.

Number 5 describes the pros and cons of the instruments devised by various research workers to identify potential delinquents.

Number 6 presents the thinking behind a recommendation for the establishment of integrated family courts and the judicial and social considerations that must be taken into account in their establishment.

DETENTION PLANNING: general suggestions and a guide for determining capacity. Edgar W. Brewer. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 381. 1960. 41 pp. 20 cents.

Noting that four out of five counties in the United States have no place except the county jail for detention of a child lawbreaker awaiting court disposition of his case, this publication discusses the need for State-administered regional detention programs and for community planning for detention facilities. Stressing the importance of physical restriction as well as guidance in detention care, it points out that such care is needed only when the child is a threat to himself or the community.

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# children

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JULY • AUGUST 1960

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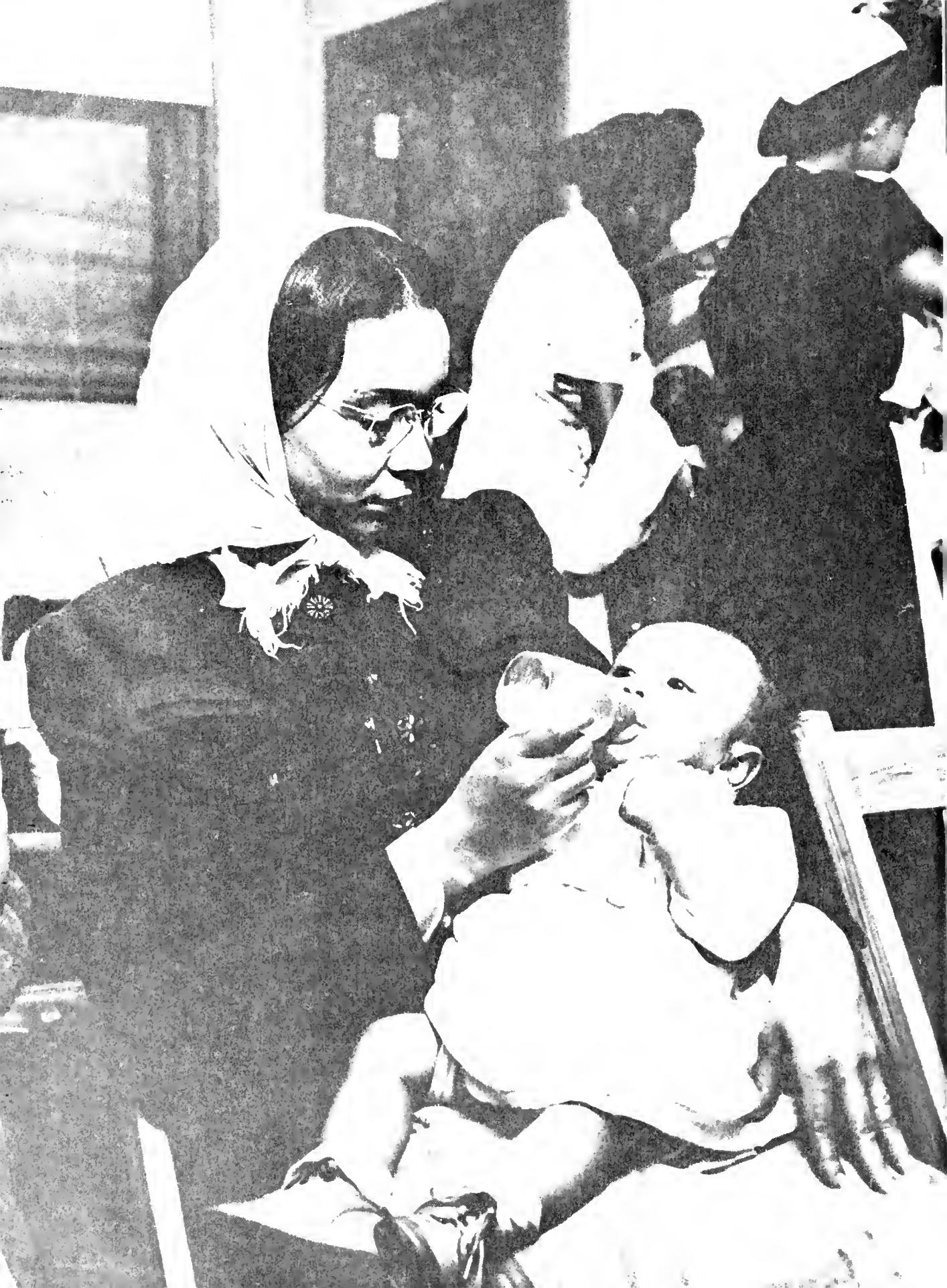
## 25 YEARS OF SERVICES TO CHILDREN UNDER THE SOCIAL SECURITY ACT

their origins, growth, and future prospects



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WAITING FOR THE DOCTOR at a well-child conference. Clinics like this one, for health supervision of babies and preschool children, have been made widely available in the States with the stimulation provided by Federal grants-in-aid for maternal and child health services under title V, part 1, of the Social Security Act.

When Katharine F. Lenroot became chief of the Children's Bureau, the planning for the Social Security Act was just beginning. As assistant to the previous Chief, Grace Abbott, she had already been in close touch with this work, and, in the months ahead, was to have much to do with the shaping of those provisions offering social services to children. Since her retirement, she has made studies for the Child Welfare League of America, International Union for Child Welfare, and Save the Children's Federation.

Before coming to the Children's Bureau in 1942, Mildred Arnold was director of the children's division in the Indiana Department of Public Welfare. With professional training from the School of Social Service Administration, University of Chicago, she has also held executive positions in voluntary child welfare agencies in Illinois.

Dr. Martha M. Eliot was with the Children's Bureau for more than 30 years before going to the Harvard School of Public Health in 1957 to head the department of maternal and child health. As associate chief of the Bureau in 1934, she helped shape the provisions for mothers and children in the Social Security Act. She has just retired from the Harvard position and is now a consultant for the World Health Organization.

A pediatrician with a public health degree, Dr. Arthur J. Lesser has been with the Children's Bureau since 1941, first as a specialist in crippled children's services and for the past 8 years in his present position. Previously, he was for a year with the New York City Department of Health and for 2 years was in private pediatric practice.

Elizabeth Boggs, left, has been connected with the National Association for Retarded Children since 1952 and its president since 1958. She is a board member of the National Health Council and a past president of the New Jersey Welfare Council. Gösta Nordfors, right, has for 19 years worked in Stockholm's program for retarded children, for 14 of them as its director.

Before taking his present position in 1954, Wayne Vasey was director of the School of Social Work, State University of Iowa. A graduate of the University of Denver School of Social Work, he has worked in Federal, State, and local public welfare agencies. He is author of a book, "Government and Social Welfare," and a contributor to professional journals.

## ◀ *the authors*

# THE CHILDREN'S TITLES IN THE SOCIAL SECURITY ACT

## I. Origin of the Social Welfare Provisions

KATHARINE F. LENROOT
*Former Chief, Children's Bureau (1934–51)*

"THE CORE of any social plan must be the child." These words are contained in the report of the Committee on Economic Security, transmitted to Congress on January 17, 1935, by President Franklin D. Roosevelt. Out of that report 7 months later—on August 14, 1935—came the Social Security Act of 1935, the first attempt by the Federal Government to deal with problems of economic security for individuals on a permanent rather than a temporary basis. The act, however, was not limited to economic aid, but provided also for certain types of public services, including services for children.

Today, as we are concerned about the effect of the "affluent society" on home life and the problems of childhood and youth, it is hard to realize that 25 years ago we were concerned with recovery from the worst economic depression in our history. While many children today live in families having marginal incomes or receiving some form of socially provided aid, the picture as a whole is far different from that of 1934, when 31 percent of the people in the United States who normally worked for wages or small salaries were out of jobs.

On June 29, 1934, the President created the Committee on Economic Security, with the Secretary of Labor, Frances Perkins, as Chairman, to draw up a program through which the Federal Government could help provide some basis of security to families and individuals. The Children's Bureau was asked by the Committee to act in a consultative capacity with regard to the parts of the program relating to child health and child welfare, including aid to dependent children. The Bureau's recommendations to the Committee were developed with the aid of an advisory committee on which both health and social work were represented, and in the light of the findings of the 1930 White House Conference on Child Health and Protection.[1]

The recommendations of the Committee were substantially incorporated in the bill which became law on August 14, 1935. It provided for income maintenance for the unemployed, the aged, and the blind on the insurance principle or through grants to the States for such of these as were in need. It also provided grants to the States for aid to needy children living with parents or relatives and deprived of parental support or care for specified reasons; for child welfare services; for maternal and child health and crippled children's services; for public health work; and for vocational rehabilitation.

Although the immediate factors which led to the enactment of the social security program lay in the economic depression, evidence of society's concern for the well-being of children had been increasing for more than half a century, and especially in the 20 years between the first White House Conference on children and the vast unemployment of the thir-

ties. The principle that children should not be removed from their homes by reason of poverty alone had been stressed by each of the decennial White House Conferences, and was incorporated in State "mothers' aid" legislation, beginning in 1911 and enacted in all but a few States by 1931. In 1934 approximately 109,000 families with 280,000 children were receiving assistance under State mothers' aid laws.[2]

Since its establishment in 1912, the Children's Bureau had made studies of many aspects of child health and child welfare and had had experience in administering grants to States under the short-lived Maternity and Infancy Act of 1921. In the country at large, great advances had been made in medical care and health services and in social work.

During the early- and mid-thirties the economic depression sharply curtailed many existing services for children, when the overwhelming needs of the period called rather for their expansion. State or local funds for mothers' aid were reduced in many States. With the imminent liquidation of the Federal emergency relief program, carried out in 1935 and replaced by a Federal works program, many needy mothers and children without breadwinners would be left without resources, unless other provisions were made.[3,4]

Resources for children who needed care away from their own homes were also sharply reduced in this period,[2] but Federal emergency relief funds were not being used for their care although homeless young people were included in a program for transients.

In its report to the Committee on Economic Security, the Children's Bureau noted that the basic service necessary to deal with conditions of neglect, delinquency, and mental disturbance or physical handicaps is child welfare service, "designed to furnish skilled investigation of the individual needs of the child and to make available the services of any agencies in the community or State that may be adapted to the particular situation." In general, however, public and private social welfare services for families and children were available only in the large urban centers. In 1932 only about 5 percent of all counties with less than 30,000 population had public social workers for such service.[3] Federal emergency relief, however, under 1933 legislation, reached into the most isolated, scattered, and financially impoverished areas, bringing social workers into many of them for the first time.

Inevitably most of the 40,000 social workers engaged in administering relief to nearly 5 million families were without professional social work training, although an effort was made to include at least one trained person in each local unit. The Federal Emergency Relief Administration also developed inservice training programs and opportunities for short periods of study in schools of social work.

### *Aid to Dependent Children*

In the development of the Committee's recommendations in regard to aid to dependent children, two different points of view, based on different types of experience, emerged. The view represented by the Children's Bureau, growing out of its observations of State mothers' aid laws, regarded the provision of aid for children in their own homes as a form of child welfare service. Under this concept, the mother receiving aid had an obligation to do her best to create suitable home conditions and care for her children, while the agency administering the aid had an obligation to give her guidance and service and to keep informed about the kind of care the children were receiving. This concept was reflected in the pioneer work done by some public child welfare agencies in devising standard family budgets not only as a basis for calculating the amount of aid to be given but also for guiding the expenditure of funds and in the studies conducted by the Children's Bureau on standards of housing, feeding, health, and education in families receiving mothers' aid.[5]

Actually this philosophy was carried out in practice only in certain areas and to a limited degree. Great diversity existed among the States in mothers' aid laws, in administrative agencies, in breadth of geographic coverage, in availability of funds, in amounts of payments, and in sizes of caseloads. Less than one-half of the local units authorized to grant mothers' aid were actually doing so. In some jurisdictions where an attempt was made to maintain budgetary standards for individual families, this was done at the price of a waiting list. The administration of aid by trained social workers was an objective which could be realized only to a small degree, especially in areas outside the large cities. Moreover, the amount of control over family expenditures and other elements of family life, exercised in greater or less degree, was felt by some to be an infringement of personal freedom.

This type of program was selective in character, leaving to other means, including general assistance or foster care, children of families in which the

mother's potentiality for providing a suitable home life for her children was poor. Its purpose was to assure continued aid for the period of the children's dependency, if necessary, and to give help to the mother in providing a good home life for her children. Such services could be given only where caseloads were small and competent workers available.

The other point of view grew out of experience in dealing with massive need during the economic depression. The Federal Emergency Relief Administration urged the enactment of a very broad type of aid which would have amounted to the establishment of a general assistance program for all needy families having children under 16. The agency proposed a definition of dependent children to mean "children under the age of 16 in their own homes, in which there is no adult person, other than one needed to care for the child or children, who is able to work and provide the family with a reasonable subsistence compatible with decency and health." It is the last clause, relating to "reasonable subsistence," that would have extended the program far beyond the purposes of the older mothers' aid programs. The relief agency also proposed, as did representatives from the American Association of Social Workers, that the program become part of greatly strengthened State public assistance programs under public welfare auspices.[4]

In its report the Committee on Economic Security expressed the opinion that fatherless and other "young" families without a breadwinner should be differentiated from permanent dependents and unemployables. Administration of the aid-to-dependent-children program, however, in the bill drafted in accordance with the Committee's recommendations, was placed in the Federal Emergency Relief Administration, which, it was thought, might be continued with new functions, and the definition of "dependent child" was broad. A clause was included in the "purpose" section of this title of the bill, "assuring as far as practicable a reasonable subsistence compatible with decency and health."[4]

In the congressional hearings on the bill, testimony in support of the provisions for aid to dependent children was provided by the Children's Bureau and other child welfare agencies, and rested chiefly on the experience under State mothers' aid legislation. As passed by the Senate the bill placed the administration of the program in the Children's Bureau, but in conference it was changed to vest administration in the Social Security Board.

As finally enacted, the Social Security Act restricted its aid to children who are "deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent," and who are living with a parent or specified relative in his own home. Thus the "mothers' aid" concept of separating out from the general relief load children in need of care because of the absence or incapacity of a parent prevailed. Federal aid was made contingent upon statewide operation of the plan, financial participation by the State, and a fair hearing procedure available to any person whose claim with respect to aid to a dependent child was denied. The purpose clause relating to "reasonable subsistence" was omitted. Certain deficiencies of the legislation have since been corrected by amendments to the act, including a lower matching ratio for aid to dependent children than for old-age assistance and aid to the blind; the failure to include financial aid for the person caring for the child; and the absence of provision for a merit system in appointments of personnel. However, differences in maximum amounts specified as a basis for calculating the Federal share in the costs of the programs still maintain an element of inequality in aid to dependent children as compared with other assistance programs.

### *The Need for Services*

The original act made no specific provision for a program of service that would help the mother in planning for her children and in developing her own strengths and capacities. The shift over the years in the predominating composition of the aid-to-dependent-children caseload from families deprived of a breadwinner by death—provided for increasingly through old-age and survivors insurance—to families whose homes have been broken by desertion or divorce or in which the father is incapacitated or the child illegitimate has intensified the need for services intended to strengthen family life. Such services have been authorized in the 1956 amendments to the act, but have been very difficult to provide on any large scale because of heavy caseloads, the shortage of trained workers, and other factors. Increasing efforts are, however, being made in this direction.

Although great gains have been achieved since 1935 in coverage, in size of payment, and in standards of administration, the aid-to-dependent-children program in many States is far from satisfactory. The aims of the earlier mothers' aid programs, to bring constructive service as well as financial aid

to families, in many places have not yet been realized. The whole problem of children needing financial aid today presents great contrasts with the situation in the depression and predepression years, and calls for different approaches.

### *Child Welfare Services*

The development in social work which led to the incorporation of the child welfare provisions in the Social Security Act was the growth in the first quarter of this century of public countywide services for child care and protection. The need for public services of this type was greatest in small towns and rural areas. A private agency, the New York State Charities Aid Association, under the leadership of Homer Folks and H. Ida Curry, played a significant role as a stimulator of public services for children in New York State, and its work had a great influence in other States.

The Children's Bureau, through studies made under the direction of Emma O. Lundberg, also encouraged the States to provide such services, as did a number of State commissions on child-welfare legislation which sprang up across the country within a few years after 1915. The primary objective of those programs, according to Miss Lundberg, "was to bring the social welfare activities of local units into close relationship with the responsibilities of State departments of social welfare and to inject the principles of social casework into the treatment of social welfare problems by public agencies."[6] By 1931, 12 States had enacted legislation creating county boards or departments to bring some social services to children, particularly in rural areas.[4]

In the early thirties the Children's Bureau tried to obtain an appropriation of $100,000 for furthering the development of county social services for children through demonstrations to be conducted in several States in cooperation with State and local officials. This request did not receive the approval of the Bureau of the Budget, and hence was not submitted to Congress. The opportunity for a broader program of aid to the States in extending and strengthening these services came with the Social Security Act.

As first drafted, the child welfare provisions of the act (title V, part 3) followed the pattern of specifying requirements which State plans must meet before they could be approved by the Children's Bureau—the general pattern of Federal-aid legislation. The State plans were to include reasonable provision for State administration, the furthering of local public child welfare services, and cooperation with health and welfare groups and organizations. This part of the bill, however, was changed to meet the objections of persons who feared that the effect of Federal aid as originally conceived would be to limit the sphere of service for voluntary agencies. The result was a highly flexible authorization, providing for the joint development of plans by the State agency and the Children's Bureau, with no requirements specified. Under this joint planning, each party could hold to the conditions it deemed necessary, the Federal grant being made to the State only if agreement was reached.

The services which could be provided by the State, with the aid of the Federal grant to pay part of the cost, were district, county, or other local public welfare services in predominantly rural areas, for the protection and care of homeless, dependent, and neglected children and children in danger of becoming delinquent. The Federal funds could also be used for State services to assist in the development of adequate methods of community child welfare organization in predominantly rural areas and other areas of special need. An annual appropriation of $1,500,000 was authorized.

In view of the broad scope of the language of title V, part 3, of the Social Security Act, and of the fact that few precedents for these services existed in most of the States, the Children's Bureau had to be exceedingly flexible in its approach to the States, adapting it as the individual situation demanded. Its success in getting programs underway in all the States was due very greatly to the leadership and personality of Mary Irene Atkinson, the first Director of its Child Welfare Division.

To aid in the development of policies, the Bureau appointed an advisory committee and held conferences of State child welfare directors. In its first report the committee stressed the importance of drawing in all the services available for children in each State or locality, using local committees and building up informed citizen interest in the program, employing qualified personnel, and developing opportunities for staff to obtain professional training. Over the years, the educational leaves granted by State child welfare agencies through the aid of Federal funds have greatly contributed to the recruitment and training of qualified personnel for public welfare programs in general, as well as for child welfare services.

When the Social Security Act became law, 11 States had no provision for statewide child welfare services for children. Two years after Federal social security funds first became available, every State but one was cooperating in the child welfare program. By the end of 1939 all the States were included.[7]

It is not within the scope of this article to discuss the impact of World War II upon child welfare programs; the developing concepts of what a comprehensive child welfare program should include; the problems presented by the inclusion in the same State and local public welfare programs of the enormous task of administering public assistance and the relatively small but intensive programs for lifting the level of services for children through providing training for workers, demonstration programs, and keeping caseloads to manageable size; the broadening of the program's scope through successive amendments to the act; the increase in amounts authorized to be appropriated as well as in actual appropriations; and the proposals made in 1959 by the Advisory Council on Child Welfare Services for further broadening and extending the program.[8]

It is, however, appropriate to point out that great unmet needs still exist among children, and to stress the importance of an approach to the problems of child welfare which include strengthening both family and community life. Methods of attack will have the greatest chances of success if they include incentives for family self-help, personal growth, mutual aid, and cooperative effort in neighborhoods and communities, with citizen understanding and participation, and the linking up of specialized services with basic local programs.

[1] Report to the President of the Committee on Economic Security. Washington, D.C., 1935.

[2] Economic Security Act. Hearings before the Committee on Finance, U.S. Senate, 74th Cong., 1st sess., S. 1130, Jan. 22 to Feb. 20, 1935.

[3] Social Security Board: Social security in America; the factual background of the Social Security Act as summarized from staff reports to the Committee on Economic Security. Washington, D.C., 1937.

[4] Brown, Josephine C.: Public relief, 1929–1939. Henry Holt & Co., New York, 1940.

[5] U.S. Department of Labor, Children's Bureau: Proceedings of conference on mothers' pensions, June 8, 1922. Children's Bureau Publication No. 109. 1922.

[6] Lundberg, Emma Octavia: Unto the least of these; social services for children. D. Appleton-Century, New York, 1947.

[7] U.S. Department of Labor, Children's Bureau: Child welfare services under the Social Security Act; development of program, 1936–1938. Children's Bureau Publication No. 257, 1940.

[8] Kidneigh, John C.: A look to the future in child welfare services. *Children*, March–April 1960.

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THE CHILDREN'S TITLES IN THE SOCIAL SECURITY ACT

# II. The Growth of Public Child Welfare Services

MILDRED ARNOLD
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IN THE 25 YEARS that have passed since the Federal Government, through the Social Security Act, took the momentous step of joining forces with the States in developing their public child welfare programs, this partnership has proved a potent force in bringing services to children.

The partnership created by the act has had some unique characteristics that have had tremendous influence on the way in which State child welfare programs have developed. These grants, the Congress determined, were not to be used to pay for part of the total cost of public child welfare services, as in the public assistance programs, but to help get new services started: to reach more children with established services; to improve the quality of services provided.

The basic purpose of Federal grants-in-aid for child welfare services has remained the same since the Social Security Act was originally passed. There were significant amendments to title V, part 3, in

1950 and 1958, but these amendments did not change the definition of child welfare services nor the concept of using the funds to extend and strengthen services.

The 1950 amendments provided, for the first time, for the use of Federal funds for the return of runaway children to their own communities in another State in cases in which such return was in the interest of the child and the cost could not otherwise be met. They also provided that in developing child welfare services for children, the facilities and experience of voluntary agencies should "be utilized in accordance with child care programs and arrangements in the States and local communities as may be authorized by the State."

The 1950 amendments also changed the basis for allotment of funds to the States, relating it to the rural child population of the State instead of the rural population as a whole. Thus an advantage was given to the States with large numbers of children living in rural areas. These amendments also raised the amount which could be appropriated to $10 million.

The most significant amendments to title V, part 3, were made in 1958. Foremost among them was the lifting of the restriction on the use of the Federal funds to rural areas, so that the funds can now be used by the States in whatever area they are needed. At the same time the authorization was raised to $17 million and Guam was brought into the program.

The 1958 amendments also brought a significant change in the way the funds were to be allotted to the States. The uniform grant allowed each State was increased from $10,000 to $60,000 if the appropriation reaches the $17 million authorized. If the appropriation is lower—which so far has been the case—the amount of the uniform grant bears the same relationship to $60,000 that the total appropriation bears to the full amount authorized. The amendment provides that the funds remaining after allocation of the uniform grants are to be appropriated to the States in relation to a combination of factors, varying directly with child population under 21 and inversely with the ratio of State per capita income to the per capita income in the United States as a whole.

Another significant change brought by the 1958 amendments is that for the first time Federal child welfare services funds must be "matched" by the States, beginning July 1, 1960. As in the allotment of funds, this "matching" is also to be done on a variable basis related to per capita income so that the poorer States will receive a larger proportion of Federal funds in relation to their expenditures for child welfare.

Because of the extensive nature of these amendments the Congress established an Advisory Council on Child Welfare Services to make recommendations to the Secretary of Health, Education, and Welfare and the Congress in regard to title V, part 3, of the act. The report of this Council was made on January 1, 1960, and on that date the Council ceased to exist.

### *Foundation for Programs*

Since the main purpose of the child welfare services grants was to extend and strengthen child welfare services, the presumption when the Social Security Act was passed was that some services already existed which could thus be extended and strengthened.

Miss Lenroot has given a picture of the great variation among the States in what they provided for children and of the meagerness of their resources.

What is the picture today? The foundation for a comprehensive program of services to children has been laid in every State. All 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands have State departments concerned with and carrying specific responsibilities for the welfare of people, including responsibility for the provision of child welfare services. In many States real progress toward a well-rounded program has been made. The partnership of the Federal Government with the States in regard to child welfare services has proved to be a strong catalyst for action.

Progressively over the years, these Federal funds for child welfare services have served as magnets, drawing out more and more State and local efforts in behalf of children. In 1959 the States and Territories spent $186 million on child welfare services. On June 30, 1959, more than 7,000 full-time public child welfare employees in professional positions were providing services to 364,300 children of whom 40 percent were in their own homes or the homes of relatives, 43 percent were in foster family homes, and 17 percent in institutions or elsewhere.

Though much progress has been made, no State has as yet a completely well-rounded program for all children who need child welfare services. But most States are moving steadily forward.

The aim of this program is to assure the availability of child welfare services to all children needing them, regardless of race, religion, economic or social

status, or length of residence in one spot. The services offered in the States today are for the most part free of many of the restrictions in other programs, such as a test of economic need or residence within the State. Where they are available, therefore, they are there to serve all in need of them. They are, unfortunately, not yet available in all counties in this country.

The professional nature of child welfare services, stimulated from the beginning by the Children's Bureau's encouragement of the use of Federal funds to provide educational leave, has steadily developed. This aspect of the program has grown until today practically every State uses Federal funds to encourage staff members to study in schools of social work. About 500 workers are receiving training this way each year. About 10 percent of the $13 million granted to the States for child welfare services in 1960 will be used for educational leave.

### *Their Scope*

In the years since the passage of the Social Security Act, the scope of the public child welfare programs has broadened and the emphasis of service has changed. In the thirties the emphasis in child welfare service was largely on care of children away from their own homes. But over the years child welfare workers have increasingly realized that every child needs a permanent home of his own, preferably with his own parents. Accordingly the focus of child welfare programs has increasingly shifted toward working with parents, who may be ill, handicapped, incapacitated, neglectful, abusive, or unmarried, in an effort to prevent the breakup of homes. This shift, in turn, has called attention to the need for resources, such as homemaker and day-care services, that can be used to help children remain at home when crises develop or when the mother goes out to work.

This emphasis on the preservation of homes has led agencies to reach out to hitherto unreached groups of people in an effort to provide services before it is too late. Thus at present, we find that social services to special groups of children, such as the mentally retarded, the emotionally disturbed, the neglected and abused, are receiving special attention in many public child welfare programs. The concept of a "home of his own for every child" becomes more real as public welfare departments expand their adoption services to serve besides the widely sought healthy white infants, children who are physically handicapped, emotionally disturbed, beyond the toddler age, or members of a racial minority, or children who as brothers and sisters need to be kept together in one family. Children such as these also need a permanent home of their own.

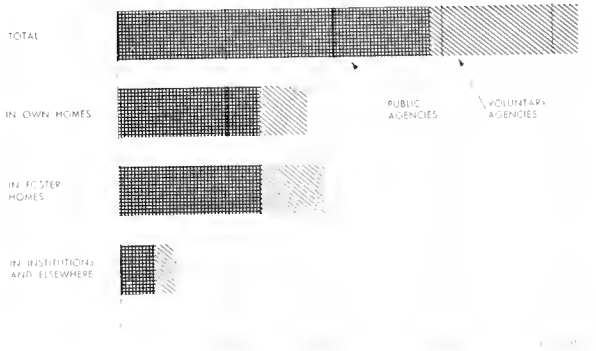
### *The Meaning of Partnership*

Although Federal funds have represented only a small percentage of the total expenditures for public child welfare programs, they have had an importance far beyond their size. As one State child welfare administrator has so aptly said, these funds have provided "seed money" that have made it possible for the States to start and nurture services in areas totally lacking them or for children and families never before served. They have made available resources to meet children's special needs, such as psychiatric and psychological services, remedial reading instruction, treatment centers for emotionally disturbed children, day-care centers for migrant children, and a host of other services that might not have flourished if their importance and value had not been clearly shown through the mirror of actual practice. They have provided professional training, institutes, refresher courses, and supervision for child welfare staff, often sorely needed in new and expanded services. They have made possible demonstration and research projects.

The "joint plan" provision of title V, part 3, of

**CHILDREN RECEIVING CASEWORK SERVICES THROUGH CHILD WELFARE AGENCIES**

**June 30, 1958**




About 417,000 children were receiving casework services from public or voluntary child welfare agencies on June 30, 1958. The chart does not show all children in institutions nor those receiving casework services from institutional staffs.

the act has greatly strengthened efforts to improve programs by furnishing the Children's Bureau and State staffs an opportunity to note each year how far the States have advanced in planning, to look at unmet needs, and to chart the course ahead.

The 1950 amendment relating to the use of the facilities and experience of voluntary agencies has stimulated efforts on the part of both public and voluntary agencies for coordination of services. Both types of agencies have the same long-range purpose—to serve children more effectively—a task which calls for a high degree of communication, cooperation, and collaboration between them.

As public child welfare programs have expanded, the realization has grown that they cannot move forward alone, for they contribute to and receive help from other programs that render services to children. Moreover, other professions besides social work are deeply involved in child welfare programs. They provide, for example, the health and medical services in foster care facilities, the educational services in group care facilities, and the medical and legal services in adoptions. Federal child welfare grant funds, guide materials, and consultation from the Children's Bureau have helped to stimulate cooperative efforts among the various professions engaged in such services.

The phrase in the Social Security Act allowing Federal funds to be used to develop "State services for the encouragement and assistance of adequate methods of community child welfare organization," has stimulated State and local welfare agencies in many places to play a more vital role in community planning for children.

### *A Look Ahead*

The services extended to children, since the passage of the Social Security Act, have been substantial and impressive. Many children have been able to remain in their own homes with their own parents; many others have found permanent homes through adoption; many have been spared a childhood in an institution and many have been saved from foster care as a way of life. But as encouraging as these accomplishments are, the goals which must be reached if the needs of children are to be met are still distant.

What are some of these goals? To serve children and their families effectively, child welfare programs must have a foundation in State law, which clearly defines the rights of children, the rights and responsibilities of parents and guardians, and the responsibility of society to serve and protect both children and their parents. This legal foundation should make possible the development of a comprehensive program of child welfare and youth services, available to all, and of the quality required to meet the social welfare needs of children and youth.

Child welfare programs in many States are operating on too narrow a legal base; confusion and overlapping exist in related laws; services are often narrowly circumscribed. Adequate State legislation can make a very substantial and lasting contribution to meeting the special problems of children and to maintaining family life for them.

The structure and organization of public child welfare programs in many States leaves much to be desired. Often responsibilities are not clearly defined, the program lacks identity, resources are meager. Overshadowed by other larger programs, the child welfare program in some places becomes an "orphan"—detached, isolated, neglected, malnourished. States and communities must be strongly convinced of the importance of the child welfare program to the welfare of children and families and of its contribution to other programs within and outside the welfare department if this is to be prevented.

Although many States have made valiant efforts to provide better financing of public child welfare programs, in many instances programs are still poorly financed. In some States where the services are locally administered, the State does not bear a sufficient share of the cost of services. The results of inadequate financing are clearly visible: insufficient workers to provide coverage of services; too large a proportion of untrained staff; high staff turnover; low board rates for children in foster care, often resulting in frequent replacements; unmet special needs of children; wide gaps in and generally low quality of services.

While 70 percent of the urban counties in the country have full-time child welfare workers in public programs, only 47 percent of the rural counties have such workers. This, in effect, means discrimination against rural children. A neglected child, an abandoned baby, or an emotionally disturbed adolescent in a rural area may have no one to look to for help, while perhaps only a few miles away in a city a child welfare worker may be deeply concerned about a child in similar straits. Complete coverage of every corner of the country with child welfare services is an important goal for the future. Its achievement depends on long-range, comprehen-

sive planning through a fusion of Federal, State, and local effort.

As unsatisfactory for many children as partial coverage of the country with services are child welfare staffs that are only partially trained. In 1957, 58 percent of the public child welfare employees had some graduate social work training; of these only 28 percent had 2 years or more of such training, the amount necessary to train a really skilled worker. Other halfway achievements mean that many loopholes remain which are perilous for children. For example, 19,500 children were placed for adoption with unrelated persons in 1958 without the protections provided by the services of a social agency; 401,000 children under 12 years of age were recently reported by the Bureau of the Census as having to look after themselves while their mothers worked away from home; most of the 4,281 children in foster homes recently studied by the Child Welfare League of America were estimated to have little chance of having a permanent home of their own during the remainder of their childhood.

While some acceleration has occurred in cooperative efforts within the field of child welfare between public and voluntary agencies and among different levels of government, and while citizen participation in planning programs has increased, still much remains to be done in broadening the base of child welfare planning. In its report the Advisory Council on Child Welfare Services pointed out that the needs for child welfare services are so great that meeting them will require maximum effort on the part of both public and voluntary agencies. This statement is reinforced by the State reports prepared for the Golden Anniversary White House Conference on Children and Youth, which repeatedly call for the coordination of effort between all agencies, public and voluntary, in all aspects of programs affecting children and youth.

Anyone concerned with these child welfare programs during the last 25 years has experienced moments of discouragement. But the steady progress in these years clearly indicates that these programs will continue to move forward.

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THE CHILDREN'S TITLES IN THE SOCIAL SECURITY ACT

# III. Origins and Development of the Health Services

MARTHA M. ELIOT, M.D.
*Former Chief, Children's Bureau (1951–56)*

THE INCLUSION in 1935 of programs to develop maternal and child health services and medical and related care for crippled children under title V, parts 1 and 2, respectively, of the Social Security Act, set in motion a new series of events in the longtime effort of many people and agencies to eliminate the hazards of pregnancy to mother and child, to assure life and health to every child, and to bring within reach of every family the health supervision and medical and related care required during the maternity period and in childhood.

The philosophy and principles of administration that influenced the initiation of these two programs were not new, but they were to be applied with a breadth of concept of what constitutes good care in health and sickness that was new. The guiding principles stemmed from a fundamental concept developed early in our history that government in a democracy has a responsibility toward all the Nation's children. In the colonial days the concept of local government responsibility for children had begun to take shape. During the 19th century, the responsibilities of the State and private agencies for the establishment of standards of care became clearer, especially for children and adolescents without parents or for those who were neglected. But the concept of partnership of the States with the Federal Government in improving the health of

mothers and children did not appear in public debate or Federal law until after the beginning of the 20th century.

The establishment of the Children's Bureau in 1912 by Congress was "an expression of a belief on the part of many people that children are the most important of the Nation's resources and that the Government should foster their development and protection by setting up a center of research and information devoted to their health and welfare." [1] Thus the national concern for children was translated into a specific public policy to focus attention on the state of well-being of children throughout the country and on their common and special needs. To accomplish this, the Children's Bureau selected areas for study and report that had nationwide significance, such as infant and maternal mortality, nutrition, methods of improving and administering child health and child welfare services at the county or city level, and State laws affecting child life. The important principle that emerged was that the eyes of planners, administrators, and workers with families must be focused not so much on procedures and rules as on the child himself and his particular needs.

### *The Maternity and Infancy Act*

In 1919 a movement was fostered by Julia Lathrop, first Chief of the Children's Bureau, to adapt the already existing public policy of Federal grants-in-aid to States, being used for public roads and agriculture, to provide new incentive to meet more adequately the needs of mothers and infants. The passage of the Maternity and Infancy Act (generally called the Sheppard-Towner Act) passed late in 1921 strengthened State and local public services, and brought to people, especially in the smaller towns and cities, knowledge of the principles of good maternity, infant, and preschool child care.

Though the Maternity and Infancy Act expired in June 1929, there were many lessons to be learned from it which were to be of great value when the Congress in 1935 reestablished under the Social Security Act the program of aid to the States for maternal and child health and added the programs of medical care for crippled children and child welfare services.

The primary effect of the Sheppard-Towner Act was educational. Among the steps it helped the States to take were: employment of full-time or part-time physicians and public health nurses by State and local public health agencies to conduct prenatal and infant care conferences in smaller cities and towns similar to those already existing in larger cities; issuance to physicians of standards of infant care and of good prenatal, delivery, and postnatal care for mothers; systematic effort to teach a few principles of good maternity care to the large numbers of untrained midwives practicing in some of the States and to supervise and license them.

This program not only taught many people what kind of care they should expect, but helped them to perceive that the State and local health agencies can play a role in giving instruction and care to individuals which goes beyond community control of infectious diseases and involves matters of personal health.

Though the program's administration was placed in the States, its planning was to a large extent a cooperative undertaking between the Children's Bureau and a unit of the State health agency, usually a maternity and infancy division. Many of these administrative units, especially where a maternity and infancy program was new, looked to the Children's Bureau for guidance and direction rather than to the State health agency itself. It is not surprising that a number of experienced health officers, however, objected to a Federal agency's dealing directly with one of their departmental divisions. When the proposed Social Security Act was under discussion in 1934, Grace Abbott, then Chief of the Children's Bureau, proposed immediately that the State responsibility for the program should be lodged in the State agency and not in a subordinate unit.

Another lesson learned from the early maternity and infancy program grew out of Congress' decision to limit its duration, at first to 5 years, and then to a total of 7. At the beginning of new undertakings the Congress is often understandably cautious in providing for indefinite support. However, there seems to have been surprisingly little realization when this program was established that many years of planning and program activity would be required to bring about large reductions in infant and maternal mortality. The failure of this small (a total of $1,240,000), but for the times, bold program to bring about a significant decrease in maternal mortality in less than 5 years, though easily understood today, fed the flames of opposition and the program was brought to an end in 1929.

Reports prepared for the President's Committee on Economic Security in the fall of 1934 showed that a number of States increased their State appro-

priations for maternal and child care immediately after the cessation of the Maternity and Infancy Act in 1929, in a few instances to an amount exceeding their former Federal and State funds combined. As the great depression of the thirties intensified, however, many States decreased their appropriations for this work. By 1934, 9 States no longer appropriated any State funds for maternal and child health; 23 had decreased their appropriations; and only 5 made appropriations equal to or above their combined Federal-State funds of 1928. It took the calamity of the economic depression, and, in 1934, an increase in the national infant mortality rate, to demonstrate that the former policy of Federal-State participation in the provision of health services to children and mothers was essential.

By 1935 the country was ready for a new and more comprehensive program of health services for children, one that would have no time limits imposed in the legislation, one that would not only stimulate the States to make greater efforts but would provide for continued extension and improvement, for demonstrations of new types of programs and new methods of operation, and for meeting the medical-care and related needs of crippled children.

### *New Health Programs*

It may seem strange today that small tax-supported programs of maternal and child health, medical care of crippled children, and child welfare services were made part of an act whose purpose was to provide economic security to workers and their families. Under discussion by the President's Committee on Economic Security were the pros and cons of including health insurance provisions in the bill, and the arguments were heated. When the bill was introduced health insurance was not included, but the discussions opened the way for consideration of grants-in-aid to the States for general public health, maternal and child health, medical care of crippled children, child welfare services, and aid to dependent children. Citizen groups, which since 1929 had been trying to persuade the Congress to reinstate the former Maternity and Infancy Act, seized the opportunity to support the new health proposals.

The Committee on Economic Security formed advisory committees on public health and child welfare, which readily accepted the proposals for grants to States for general public health, maternal and child health, and medical care of crippled children. In the course of discussions among public health advisers and staff some questions arose as to whether the funds for the children's health services might not be combined with those for general public health and handled by the Public Health Service while the Children's Bureau provided technical advice. The impracticality of establishing by law a policy of separating the authority over funds from the provision of technical assistance led to the withdrawal of the proposal. In the advisory committee on medical care, where the debate had been concentrated on the proposals for compulsory health insurance, little attention was given to the small proposal for medical care of crippled children.

On August 14, 1935, with Presidential approval of the Social Security Act, the expanded program of grants to States for maternal and child health and the new program for medical care of crippled children and for child welfare services came into being. By omitting any time limit for these programs, Congress adopted the position that the Federal Government has a responsibility to use its central taxing power to assist the States on a continuing basis in their efforts to improve the health and welfare of mothers and children. The clear intent of these measures was to increase opportunities for health and social development of all children no matter where the child happened to live.

The responsibility for administering the programs and approving State plans was given to the Chief of the Children's Bureau, though the rulemaking power, the allotment of funds, and the authority to hold hearings were reserved at first to the Secretary of Labor, under whose supervision the Children's Bureau then operated, and later—as organizational changes in the executive branch of the Government took place—to the Federal Security Administrator, and then to the Secretary of Health, Education, and Welfare. Over the years the Children's Bureau through delegated authority has in fact administered the program and approved State plans.

The original act contained authorization for appropriation of $3,800,000 for maternal and child health services, $2,850,000 for medical care of crippled children, and $1,500,000 for child welfare services. Dollar-for-dollar matching was required for $2,820,000 of the funds for maternal and child health and for the total amount for crippled children's services. Of the sum for maternal and child health, however, $980,000 was set aside for allotment to the States "according to the financial need of each State for assistance in carrying out its State plan." No matching by the States was required for this amount.

From the number of the section providing for this allotment, 502(b), it soon acquired the name of "Fund B" by which it is still known. The use of this fund to finance the special maternal and child health demonstrations required in the section on plan approval, as well as to meet other particular needs, such as training, quickly proved its stimulating value.

In 1939, when the act was first amended, a similar provision for a Fund B was made for the crippled children's program, and $1 million was added to the authorization for this purpose. At this time, also, requirements for a merit system were included in parts 1 and 2 of title V.

Gradually during 25 years the ceilings placed on amounts authorized for appropriation have been increased until in 1958 the amount for maternal and child health reached $21,500,000, and that for crippled children's services $20 million. In 1946, the total amount authorized for each of these programs was divided equally between the sum that had to be matched and that which did not (Fund B).

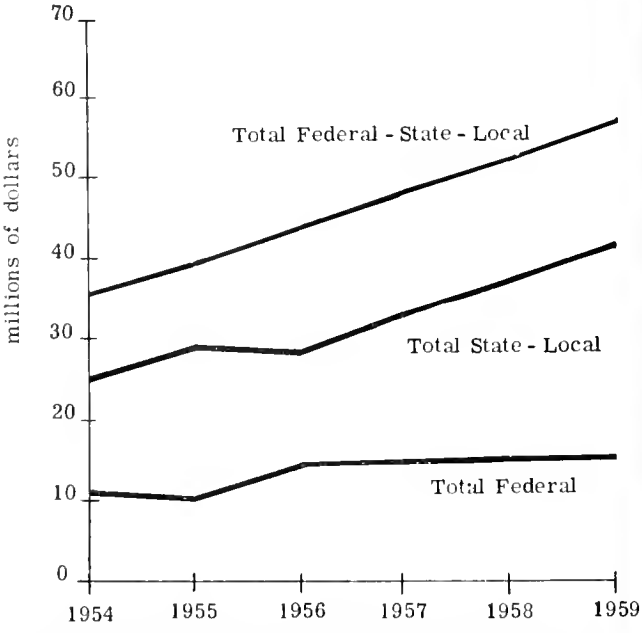
The language of the "purpose" sections of the act's provisions for these health programs and the conditions the act sets for approval of State plans provided basic policy related to their content, scope, and administration. These sections made clear the Congress' intent that the program be the States' program, not one in which the Federal Government would "cooperate" with the States as in the Maternal and Infancy Act; that the State and local services be extended and improved; that special attention be given to mothers and children in rural areas and areas of economic distress; that the program be supported at least in part by State, in contrast to local funds, and that it be administered by a State agency or by local units under supervision of a State agency in accordance with a system that would assure efficient operation.

In order to coordinate the maternal and child health program closely with the general public health program of each State, the act required that the State health department be responsible for administration. It did not, however, explicitly set this pattern in regard to the crippled children's program. In a few States already established programs for crippled children were being administered by an agency outside the State health department. Unwilling to interfere with such arrangements, the Congress left it to the States to decide which agency should administer these medical care programs.

However, practically every State which established new programs under the stimulation of the Federal act gave the State health department administrative responsibility. A few States have transferred responsibility formerly placed in some other agency to the health department; a few others, still administered by an agency other than the State health department, have found ways of coordinating State and local services so that the benefits of the preventive child health program under the health departments could be made available to "crippled" children as well as others. Only one State has transferred the responsibility for crippled children from one nonhealth agency to another.

Some States have taken advantage of the broadly stated purpose of the maternal and child health provisions to develop programs of medical care for groups of handicapped children not otherwise provided for. This stated purpose was to extend and improve health services for mothers and children generally, presumably by any means that a State decided to use provided it stayed within the conditions laid down in the plan-approved section. Two conditions for plan approval gave particular emphasis to improving the quantity and quality of care of children in their own communities: (1) provision in

**CRIPPLED CHILDREN EXPENDITURES**




In recent years State and local expenditures for crippled children's services have become an increasingly larger proportion of the total public expenditures for such services.

the plan for extension and improvement of locally administered maternal and child health services; and (2) provision for demonstrations in needy areas or among groups of children in special need. The implication that standards of care, service, and qualifications for personnel would be set up in the State plan was plain.

While the act made the States responsible for the establishment and implementation of standards of care and for efficient operation of the maternal and child health programs, it did not limit them to applying conventional measures of prevention or care, to serving any particular groups of mothers or children, or to taking any specific steps. It left them free to extend the scope of care as new knowledge was acquired and to extend basic or special services geographically as funds increased. They could use their grants to learn new methods of prevention, treatment, or program operation; to intensify services for groups of children or mothers with special needs; to apply new knowledge through the organization of special demonstration projects. They could develop a wide variety of training opportunities for personnel. They were not required to apply an economic means test to persons served.

The purpose section of the provision for crippled children's services was more specific. It required a State's program to include services for finding children who are crippled or suffering from diseases that lead to crippling and to provide them with medical, surgical, and corrective services and care and facilities for diagnosis, hospitalization, and aftercare. No partial programs, leaving out, for example, adequate diagnostic or followup care were to be approved. The way was, however, open for broad programs, since the act contained no definition of a crippled child and put no limit on the types of crippling conditions a State could include in its plan. The States could use funds for ill children in danger of becoming crippled. They could study and explore methods of prevention or treatment.

As in the maternal and child health provision the phrase "extend and improve" in the act's provision for crippled children clearly set quality as an objective. The State agencies were expected to establish standards of care, qualifications for personnel, and standards of administration that would assure an ever-rising quality of medical and hospital care.

Since the act made no mention of a means test, each State had to make its own decision in this regard. Thus the States faced the question of whether a means test would raise barriers against the equal application of high standards of care for all children or would exclude any child from the services before the full course and cost of diagnosis and treatment were known.

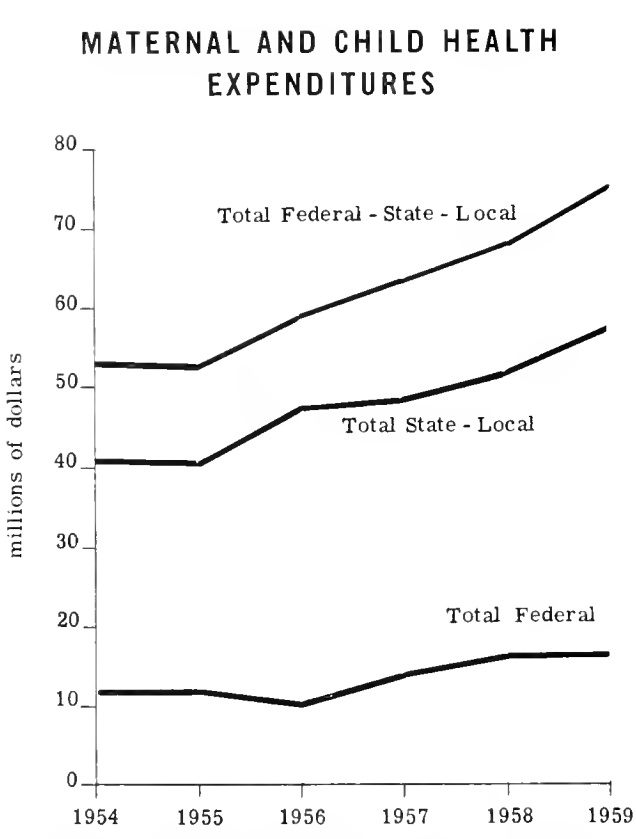
In the early years of the administration of the crippled children's program, it became evident that effective operation of a medical care program involved continued effort to keep up to date information on the course of treatment each child was receiving and on supervision by the State administering agency. Such a system required State professional personnel and advisory groups to plan and provide continued consultation on program content. It meant devising methods for: technical administrative authorization and periodic reauthorization of care for each child; appropriate fiscal control; reporting from vendors of service; cost accounting in hospitals to permit payment for care on a cost basis; and appropriate methods of payment to physicians and hospitals.

### *Development of Policies*

In both the maternal and child health and crippled children's programs, the policies set up in the act have proved to be sufficiently flexible to allow the States to develop the services as rapidly as funds, basic knowledge of prevention and treatment methods, and availability of qualified personnel would permit. The absence of a time limit on the program has meant that planning could be done on a long-term basis providing for steady growth and improvement.

In 25 years there has been no need to modify the statements of public policy as set forth in the purpose sections of parts 1 and 2 of title V. The only new policies that have been introduced through amendments to these two provisions have: (1) provided for the establishment of merit systems by the States; and (2) deleted a clause allowing funds unused at the end of a fiscal year to be carried over for two succeeding years.

In carrying out it administrative functions the Children's Bureau has directed its attention toward stimulating improvement in the quality of care, experimentation by the States in new programs and methods, and increased use of multidiscipline groups of professional personnel; and toward focusing the States' attention on the child as a person rather than only on the part of him affected by illness or impairment, or on procedure for procedure's sake. This emphasis on quality has been the controlling force within the Bureau, whether the immediate task has




Gradually increasing Federal expenditures for maternal and child health services have been accompanied by rapidly increasing State and local expenditures for such services.

been to devise formulas for the distribution of funds, to advise on standards for a merit system, to seek increases in the Federal funds for the States, or to review State and local programs.

Over the years the Children's Bureau has continuously consulted with a conference of State health officers and directors of crippled children's programs, giving their opinion great weight in reaching policy decisions. Where there have been differences of view, time has been allowed for the States to make adjustments before proposed policies have been made mandatory.

At the beginning of the programs in 1936 only one program policy was promulgated as a regulation. This required the State administration of the programs to be organized in distinct units of the State agency under the direction of a physician responsible directly to the State health officer. Experience under the Maternity and Infancy Act had shown that the maintenance of standards required programs involving the provision of health services and medical care to children to be under the direction of a person who was a graduate in medicine, preferably trained and experienced in pediatrics or in the administration of a maternal and child health program. In the beginning of the programs it was also found necessary to define certain provisions of the act, such as "demonstration services." This was done at first not through regulations, which when published have the force of law, but as stated Children's Bureau policies which could be modified as shown to be desirable.

As policies were demonstrated with time to be necessary for efficient administration, or otherwise in the interest of the children, they were formulated into regulations. In 1949 there was a careful review of all regulations for both programs, and in 1950 an integrated, detailed compilation was promulgated by the Secretary and issued as part of the Bureau's operational manual, a significant compilation of public policy in relation to standards of medical care and the protection of interests of the patient and the rights of vendors of services. Such regulations, for example, require the States to describe their standards for personnel and facilities in their State plans, to limit their program's provision of hospital and similar services to individuals receiving medical services under the plan; and to make their diagnostic services under the crippled children's program available to any child without charge, without restriction or requirement in relation to his family's economic status or legal residence, and without requirement that he be referred to any particular individual or agency.

### *Emergency Maternity and Infant Care*

Many policies related to the provision of medical care adopted originally for the crippled children's program were made effective later for maternal and child health when, in 1943, the wartime emergency maternity and infant care program came into existence by act of Congress. The purpose of this program, which lasted until 1948, was to provide complete maternity care for the wives of servicemen in the four lowest pay grades without cost, as well as health supervision and medical care for their infants up to 1 year of age. Services and care under the program were financed entirely by the Federal Government. It was administered by the Children's Bureau in accordance with the policies and regulations established for the maternal and child health program under Social Security Act.

The decentralization of administration of this emergency program to State health agencies and

within States in many cases to local health agencies as in the title V programs, was the element that made possible the provision of care and services of high quality to approximately 85 percent of the persons eligible for care. The State health agencies and their local counterparts organized their own and many other resources in their States to marshal the necessary services. Leadership was provided by the State health officer and the director and staff of the State health department's maternal and child health division, with appropriate contributions being made by the divisions of local health services, public health nursing, and crippled children's services, and the statistical, licensing, laboratory, and financial units. The contributions of State and local services had an immeasurable effect on the quality, promptness, and availability of care.

The components of the task which the health departments faced in this emergency program were the same as those with which they were familiar in connection with the other programs. They included the provision of medical, hospital, nursing, and social services, specialist consultation, blood banks and other resources for emergencies, recording and reporting procedures, and information on services available. However, relationships with hospitals and practicing physicians had to be renegotiated on the basis of a nationwide program that, by its universal application to families of a specific population group, required certain nationwide standards.

The early period of operation of the wartime expanded maternal and child health program was one of stress and strain for the State and local health departments. A great burden of work was suddenly placed upon them, made more difficult by the fact that the Congress did not provide for State administrative costs until the program was in its second year. Some of their difficulties were inherent in the fact that the program, being national in scope, demanded compliance with certain national standards of care, service availability, and procedures of reporting and fiscal accounting. Nevertheless, the health departments responded in an amazingly effective way within the limits of their resources.

The Children's Bureau had the multiple responsibility of making national policies with respect to standards and procedures, advising the States on the technical aspects of the program, and approving State plans for its operation. It is much to the credit of the State health departments that smoothly running administrative machinery was developed. Under this program 1,222,500 mothers were given maternity care, and 230,000 infants medical care, at a total cost of $126,922,316. Thus State health departments had an unprecedented opportunity to become familiar with the administration of a large-scale, public medical care program that provided services rather than cash benefits. The program gave them the experience of taking federally required minimum standards of care and administrative policies and finding a way to make them a part of State and local procedure.

The experience also gave State health agencies an opportunity to test widely and sharpen up standards of care already in use in crippled children's programs. It also gave them a chance to test federally established policies on payment for care to hospitals and physicians, such as those establishing rates of remuneration, requiring full payment to be made to vendors of care, and prohibiting them from charging patients additionally. Many States struggled with the problem of differential payments for general practitioners and for specialists—which required a definition of qualified specialists—usually concluding that only one rate for all was feasible.

### *Recent Developments*

With the discontinuance of the wartime emergency maternity and infant care program, State health departments and other crippled children's agencies could concentrate their attention on extending the programs under title V to meet the needs of the rapidly increasing child population and finding new ways to improve the services. This has been accomplished through strengthening programs for training medical, nursing, nutrition, and social work personnel, and by extending service in additional directions to provide care not only, as traditionally, to children with orthopedic problems but also to prematurely born infants and to children with epilepsy, congenital heart disease, hearing or vision impairment, amputations, mental retardation, or emotional disturbance.

The stimulating effect of the Federal funds is indicated by the fact that over the years, contributions to these services from all levels of government have increased. In the aggregate, local and State funds have gone up at a faster rate than Federal funds. In recent years, however, decrease in the value of the dollar and the rising costs of modern medical and hospital care have been reflected in a smaller increase in the number of mothers and children served than might have been expected from the increases in funds available. Nevertheless, at



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least three times as many children are cared for today under the crippled children's program as in 1940.

A few States have developed effective methods of evaluating some aspects of their programs. Increasingly as new projects are developed, methods of appraising their success are being built into them.

Since one advantage of the programs was their flexibility in allowing each State to develop services at its own pace, the States have not advanced uniformly. This lack of uniformity has had its disadvantages, however, since it means that many mothers and children still do not have available the facilities and skilled services that could have been made available with more rapid development of training facilities; general and special preventive, diagnostic, and treatment services; a wider variety and greater number of facilities for health supervision and medical care; and better compensation of professional and supporting personnel.

Some States have supported professional training facilities that have been made available to personnel from other States. But the training of medical, nursing, and social work personnel for the high quality of public service required in those programs has gone forward at a rate far short of the pace required to keep up with the growth of the child population and expanding knowledge in the medical and social sciences.

Some progress has been achieved by groups of political subdivisions, such as thinly populated counties, in cooperative planning and in pooling funds to make available basic health staff, supervisory and leadership personnel, and facilities. States have also grouped together to utilize Federal funds on a regional basis for highly specialized diagnosis, treatment, and aftercare programs required for children with certain types of crippling conditions, such as congenital heart defects or amputations, thus making good care available to many children who otherwise would not have access to it.

Today health, welfare, and education authorities and private agencies cooperate with each other more often than they did 25 years ago to utilize each other's skills and services for the benefit of children. As each group is better equipped with personnel and facilities to carry out its own work, it becomes apparent that the exchange utilization of the skills and facilities peculiar to the primary function of each group provides in the long run better care for children. Though progress is being made in such interdisciplinary activities, there is still much room for closer coordination of agencies, more joint planning, and an accelerated exchange of ideas and professional skills.

[1] Bradbury, Dorothy E.: Four decades of action for children; a short history of the Children's Bureau. U.S. Department of Health, Education, and Welfare. Children's Bureau Publication No. 358. 1956.

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THE CHILDREN'S TITLES IN THE SOCIAL SECURITY ACT

# IV. Health Services—Accomplishments and Outlook

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A PERVASIVE THEME expressed throughout the 1960 White House Conference on Children and Youth was the need for planning to meet problems brought about by the rapid and complex social changes taking place in our country. The extraordinary progress that has been made in the protection of the health of mothers and children during the past 25 years is a source of great gratification. But a few cracks in the structure of our health services have appeared recently which should remind us that the progress made can be lost unless society is responsive to these changes.

In 1957, for the first time in 22 years, the infant mortality rate (deaths of infants under 1 year per 1,000 live births) increased to 26.3 from 26 the year before; it increased again in 1958 to 27.1 and, according to provisional figures, declined only slightly in 1959 to 26.4. Large numbers of pregnant women are reported as coming to delivery with little or no prenatal care. In a paper given at the White House Conference, a professor of maternal and child health told of a study which showed that 34 physicians serving child health conferences in one city spent an average of 4 minutes with each child. The resources in that city as in so many others have not been increased to keep up with the increase in the child population.

A study conducted in California a few years ago indicated that the health supervision of 20 percent of the infants in the State involved no more than one visit, if any, to a physician, and that 36 percent were considered adequately immunized against diphtheria, pertussis, and tetanus.

Paralytic polio in recent years has become predominantly a disease of preschool children of low-income families, but only about one-half of the preschool population in this country is adequately immunized against it.

### *Showing Progress*

We have made little progress in decreasing perinatal mortality and in preventing handicapping conditions among children which may be traced to prenatal or natal causes. We have the information, however, which, if applied, would reduce the number of such perinatal casualties. We know that premature birth is more apt to be accompanied by neurological damage to the infant than full-term birth. We know that there is an association between inadequate prenatal care and premature labor. In the District of Columbia, for example, where the incidence of prematurity is about 10 percent for the city as a whole, it is 22 percent for women who give birth without having had prenatal care. What we know about preventing unfortunate outcomes of pregnancy is not being adequately applied. We may actually be losing ground in our preventive health services for mothers and children.

What are some of the factors which are making it essential to consider what must be done to hold our gains and make further progress? The most outstanding are: (1) the increasing child population; (2) social changes having a bearing on public health; (3) the increasing costs of medical care; and (4) changes in the practice of medicine and public health arising from the findings of recent research.

### *Population Changes*

According to Bureau of the Census estimates, in 1935 there were 48,500,000 children under 21 years of age, in 1960 there were 73,300,000, and by 1970 there are expected to be 91,300,000, or 42.3 percent of the population. By 1970 we may be having about 5,600,000 births annually, an increase of about 30 percent from 1959. The aging population is also increasing rapidly. The slowest growing group is in the age range 25–64 years.

This means that children and the aged who lean most heavily upon our tax-supported and voluntary resources are increasing much more rapidly than the segment of the population which earns the money, is the source of tax revenue, and bears the major responsibility for child rearing. The outlook for working adults is greatly increased child-rearing responsibilities and increased financial demands.

In the coming years the budgets for our health services must increase appreciably merely to keep up with the growth of the child population. We must also anticipate an increase in the proportion of infants attending public child health conferences—from approximately 13 percent at present to 17 percent in 1970. More children will also mean an increase in the number of handicapped children. During the next decade if State crippled children's programs just keep up with the increase in child population and grow no more rapidly than during the decade 1950–59, the number of children for whom they will be providing medical services will nearly double—from 325,000 in 1958 to over 625,000 in 1970.

The estimated costs of the maternal and child health and crippled children's programs through 1970 consistent with the expected increase in the child population and assuming no more than the recent rate of growth of these programs are shown in tables I and II.

The changes in the population composition of large cities are creating new social and public health problems. While related to the more general and familiar phenomenon of the increasing size of metropolitan areas, the problems of large cities are distinctly different from those of the surrounding metropolitan counties. As middle-class families move to the suburbs, low-income families remain and others move in. Thus an increasing proportion of the resident population of most large cities is in the low-income group which is dependent upon commu

nity agencies for health supervision and medical care.

For example, only 10 percent of the resident mothers who gave birth in the District of Columbia last year were delivered by private practitioners; 60 percent were delivered by hospital service staff physicians. Of the women who gave birth at the District General Hospital, 45 percent received no prenatal care at all.[1] Because of the increased number of deliveries at the District General Hospital, mothers and infants are often sent home within 24 hours after delivery to make room for other patients. Because of long waiting lists for admission to the city's well-baby clinics, babies in their first year are given priority. Some 16,000 children of preschool age are not receiving health supervision.

In Baltimore attendance at well-baby clinics during the past 10 years has increased 50 percent, and at prenatal clinics 75 percent.

In New York City one-third of the city's infant population receives its well-child supervision at the city health department's well-baby clinics.

The New York Academy of Medicine estimates that by 1965 one-half of all deliveries in Manhattan will be of medically indigent patients, and adds: "The omission of prenatal care in this borough is rising about 2 percent per year. This reflects the marked increase in the number of individuals who are seeking care and who are unable to find it in a satisfactory manner."[2]

Similar examples can be found in large cities all over the country, many of which have not been able to respond adequately to the growing volume of dependency in their populations.

To a considerable extent, the readiness of children to enter school is influenced by the health supervision they have had in the first 6 years of life. Such supervision falls off sharply after infancy so that a large proportion of children begin school with health problems requiring attention. School health services have expanded considerably, but whether such expansion is effective in improving the health of school-age children is debatable.[3]

### *Reducing Infant Mortality*

Despite the great progress which has been made in improving the health of mothers and children in rural areas, rural counties have higher mortality rates than urban areas. Thus, in 1957, maternal mortality was 5.3 deaths of mothers per 10,000 live births in nonmetropolitan counties and 3.3 in metropolitan counties, a difference of 60 percent. There is, however, less difference in infant mortality rates—27.8 in nonmetropolitan counties and 25.4 in metropolitan counties.

As infant mortality declines, the rate of reduction can be expected to decrease. But infant mortality in the United States is far from having reached an irreducible minimum. The range of difference among States is considerable—20.9 per 1,000 live births in Iowa to 39.4 per 1,000 in New Mexico in 1957. Other countries have achieved lower rates than the United States.

Further progress in reducing maternal, fetal, and infant mortality and morbidity could be made through the provision of—

- Adequate prenatal care for all expectant mothers, with particular attention to women with present or past histories of complications of pregnancies and to women at either extremes of the childbearing period. Such care may require the attention not only of doctors and nurses, but also of other professional staff such as nutritionists and medical social workers.
- Hospitalization at any time for women with complications of pregnancy, including those which predispose to premature birth, and provision for care at home when appropriate with the help of medical and other home care staff.
- Consultation from obstetricians and other specialists, when needed, for all pregnant women. The New York Conference on Perinatal Mortality has stressed the importance of making specialist consultation available day and night and cited four specific conditions in which it should be mandatory: abnormal presentation, operative delivery, bad obstetric history, and medical complications.
- Hospital care for small premature infants and for full-term infants in need of specialized care, in units equipped and staffed to meet their needs.
- Home care from medical and nursing personnel when hospitalization for delivery must be brief. The use of a multidiscipline team as an extension of hospital services into the home would help to provide the needed continuity of care.

Continued progress in maternity and newborn care is dependent not only upon adequate financing but also upon the availability of professional manpower. Though the number of annual births may increase by nearly 30 percent by 1970, the number of physicians is expected to increase by only about 18 percent. How then will adequate care be provided? A few obstetricians have suggested the use of nurses

who have had special training in midwifery in hospital obstetric departments. The function of the nurse-midwife is a subject of controversy in the United States. Only through demonstrations and studies can the feasibility of this suggestion be determined.

### *The Mentally Retarded*

Since 1957, when the Congress first earmarked $1 million of maternal and child health funds for grants for special projects for mentally retarded children, services for these children have rapidly increased. Forty-four State health departments now provide such services, including the 31 supported by these earmarked funds. Approximately $2 million in Federal maternal and child health funds is being used for this purpose. During the calendar year 1958, 38 States reported the provision of health services for 6,700 retarded children. About 75 percent of these children were under 9 years of age.

The objectives of the program for mentally retarded children are the same as some of those of the entire maternal and child health program: health supervision, preventive health services, the fostering of good mother-child and family relationships; the promotion of an understanding of the processes of growth and development. The provision of these services to meet the special needs of the mentally retarded child requires establishing a diagnosis of the child's condition and an evaluation of his potentialities for growth, such as can be provided in a special clinic for the mentally retarded.

The staff of the mental retardation clinic usually includes a pediatrician, who is generally the director, a psychologist, medical or psychiatric social workers, public health nurses, and in some clinics a child development specialist, a speech therapist, and a nutritionist. The services of psychiatrists and other medical specialists are provided on a consultant basis. With the diagnosis completed, a more or less continuous relationship must often be maintained with the family by the social worker if the family is to be helped. But many families live far from the nearest clinic and cannot attend regularly. One of the problems encountered in these programs is how to secure continuing counseling and social casework services for families in small cities and rural communities.

What is most meaningful to the parents is the help they receive in home training in regard to everyday living with their retarded children. Public health nurses can help the parents of these children in their own homes in the same way that they help the parents of normal children in the maternal and child health program, since the processes involved in guiding many mentally retarded children to achieve degrees of self-help are basically the same as in normal children.[4] The nurse's contribution, however, is dependent upon a thorough evaluation of the child and his family and the maintenance of a continuing relationship with the clinic staff. Most of these programs are offering public health nurses consultation and inservice training in mental retardation and in growth and development.

Table I

**EXPENDITURES FOR MATERNAL AND CHILD HEALTH SERVICES**

**Reported for Fiscal Years 1954–58 and Projected for Fiscal Years 1965 and 1970**

| Year | Amount (dollars) [1] | | | Average amount per child (cents) | | | Estimated civilian population under 21 [2] |
|---|---|---|---|---|---|---|---|
| | Total | Federal | State and/or local | Total | Federal | State and/or local | |
| 1954 | $53,307,790 | $12,318,590 | $40,989,200 | 88 | 20 | 68 | 60,873,000 |
| 1955 | 52,297,800 | 12,140,032 | 40,157,768 | 83 | 19 | 64 | 62,834,000 |
| 1956 | 59,765,847 | 14,979,027 | 47,786,820 | 92 | 18 | 74 | 64,715,000 |
| 1957 | 63,853,176 | 14,972,935 | 48,880,241 | 96 | 23 | 73 | 66,000,000 |
| 1958 | 68,538,991 | 16,643,626 | 51,895,365 | 99 | 24 | 75 | 69,000,000 |
| 1965 [3] | 112,585,950 | | | 135 | | | 83,400,000 |
| 1970 | 156,910,000 | | | 170 | | | 92,300,000 |

[1] Source: For fiscal years 1954–58, Joint Financial Report Form 11.1

[2] For 1954–57, estimates are those used in apportionment, as prepared by the Bureau of the Census and the Children's Bureau. Estimates for 1958 are from Bureau of the Census, P 25, No. 193, adjusted to include Territories and possessions (+2.4 percent).

[3] 1965 estimates calculated Apr. 10, 1959.

A number of projects are located in teaching hospitals and are being used for the training of medical students, interns, and other professional personnel, thereby incorporating into basic professional training present-day concepts of mental retardation and its medical, social, and educational implications. The possibility of preventing mental retardation in children with certain disorders of metabolism such as phenylketonuria has stimulated much interest among clinical and research physicians as well as among health departments and institutions.

During the next few years some of the following features of health services for mentally retarded children should be explored:

- Expansion of community programs for mentally retarded children to provide diagnostic, evaluative, and preventive health services and social services for the family.
- Greater development of the child health conference as a means of early case finding and supervision.
- The use of school health services as a means of bringing medical diagnostic skills into the identification of children requiring special classes for the mentally retarded.
- Development of standards and licensing practices for the growing number of nursery and day care programs for young mentally retarded children.
- Development of home assistance programs for parents who are caring for retarded children at home.
- Development of standards for residential facilities and methods of promoting closer relationships with community clinics.
- Development of specialized services for retarded adolescents.

### *The Physically Handicapped*

Significant changes are taking place in the State programs for handicapped children, quantitatively as well as in scope and concepts. Some 325,000 children received medical services in these programs in 1958—or 4.8 per 1,000 of the children under 21 in the United States. This is twice the 1937 rate.

The proportion of children receiving hospital care in these programs has been decreasing, constituting 16 percent of the caseload in 1958 as compared with 27 percent in 1937. The duration of hospitalization has also declined, from 44 days in 1937 to 23 days in 1958, the shortest average hospitalization since the establishment of the programs.

In part the decrease in hospital care is attributable to the changes in the predominating diagnoses in these programs. Initially they consisted almost entirely of orthopedic service, but in 1958 orthopedic handicaps constituted a little less than 50 percent of the diagnostic conditions reported. Major changes since 1950 include: epilepsy, up 596 percent; congenital malformations, all types, up 94 percent; congenital heart disease, up 451 percent; hearing impairment, up 105 percent; mastoiditis, down 43 percent; osteomyelitis and periostitis, down 47 percent; poliomyelitis acute, down 89 percent; paralytic poliomyelitis, down 10 percent.

The increasing number of children who are receiving only outpatient services and their many different kinds of handicapping conditions call for more attention to the quality of outpatient care. The trend toward ambulatory care is paralleled in pediatric care generally, as physicians increasingly treat children in their offices for conditions which hitherto required hospitalization. But work on standards of hospital care has been concerned almost entirely with the inpatient service. It is time that recommended standards for outpatient services were developed with attention to the organization of services for handicapped children.

Research during the past two decades has produced many dramatic developments in medicine. Some, for example the production of antibiotics, have had a revolutionary and widespread effect upon medical practice and public health. Those that particularly affected crippled children's programs include—

- The reduction in the incidence of rheumatic fever and the prevention of recurrent attacks.
- Drugs that control epileptic seizures to an increasing degree.
- The Salk polio vaccine.
- The diagnosis and surgical treatment of congenital heart disease.
- The electronic hearing aid and its use in childhood.
- The new functional artificial hand.
- The drug treatment of tuberculosis.
- The increased understanding and application of the principles of physical and emotional growth and development.
- The extension and improvement of community programs for the care of handicapped children.

Developments such as these are bringing about changes in the composition of the diagnoses among the children seen in both the outpatient and inpatient departments of hospitals and in pediatric practice

generally. A growing proportion of these children have long-term illnesses and handicapping conditions. In some teaching hospitals children with congenital anomalies or congenital heart disease constitute between 30 percent and 50 percent of the inpatients. If such proportions are widespread, this has major significance for the design of hospitals, for medical teaching, and for the future of pediatrics and the crippled children's programs.

While we have evidence that the composition of the diagnoses in both inpatient and outpatient departments has changed greatly, this is for the most part impressionistic. Studies are needed to give a clearer picture of the children being admitted to hospitals now in comparison with those of previous years.

Albert Snoke has pointed out many other ways in which these changes are affecting hospital requirements:

> Experience throughout the country indicates steadily decreasing occupancy in children's convalescent units and general hospital accommodations. Children are being treated at home rather than in hospitals, as there are a greater number of well-trained pediatricians and fewer children's diseases requiring prolonged hospitalization. . . . All this requires fewer children's beds, smaller hospital pediatric units, greater flexibility in the use of hospital beds, and a corresponding increase in facilities for the ambulatory care of children.
>
> Newer concepts of the needs of the child in the hospital, such as the necessity for a homelike atmosphere, liberalization of visiting rules and allowing parents to remain with children in the hospital are causing not only complete rethinking of the medical and nursing staff but also replanning of pediatric divisions to accommodate the parents and visitors comfortably and efficiently.[5]

Especially significant for future planning are those centers for handicapped children which are attempting to meet the needs of children with single or multiple handicaps within one organizational unit of the hospital. Through such units all the information needed about a child can be brought together in one place with one physician responsible for the patient, despite referrals to a variety of the hospital's departments.

Pediatric education up to now has been principally concerned with medical rather than surgical or physical problems. However, with pediatricians being called upon increasingly to participate with surgeons, public health nurses, social workers, psychologists, audiologists, and others in clinical services for physically and mentally handicapped children, some reorientation is needed in medical education to give greater emphasis to the problems of handicapped children. As an editorial in the *Journal of Pediatrics* has pointed out, the pediatrician must "be equipped by training and interest to supervise and plan the general problem of the care of handicapped children. . . . He cannot simply consider his responsibility is over by referring the child to the orthopedist, ophthalmologist, or other specialist . . . ."[6]

### *Major Problems*

While the incidence of certain handicapping conditions, such as paralytic poliomyelitis, rheumatic fever, osteomyelitis, mastoiditis, and tuberculosis, can be expected to continue to decline, other problems are coming to the fore. The widespread use of antibiotics has resulted in the survival of many children with hitherto fatal illnesses, some of whom will be handicapped all their lives. As research provides new methods of treating handicapping conditions for which no treatment was previously available, children with these conditions are coming to State crippled children's agencies for care.

Of increasing significance is the collection of handicapping illnesses known as inborn errors of metabolism. While the number of children with any one of these conditions is not large, in the aggregate they are considerable. Thus far, 48 diseases have been identified in which a hereditary biochemical defect has been demonstrated. These are disabling illnesses for which "the union of biochemistry and genetics offer a rational approach to diagnosis, prevention and treatment."[7]

Congenital anomalies, comprising a large proportion of handicapping conditions of childhood, seem to be increasing. While this may be due in part to the more frequent survival of premature infants and term infants born with serious impairments, some authorities believe that the increase may be in part attributable to a rising level of mutagenic agents.

### *Congenital Heart Disease*

Developments in relation to congenital heart disease illustrate how the application of productive research brings about major changes in crippled children's programs. Between 30,000 and 50,000 children are born each year with this condition. Hardly more than 15 years ago there was virtually nothing that could be done for them. With development of the "blue baby operation" in 1945 and, more recently, open heart surgery, the outlook has completely changed. It is now reported that surgery can result in cure or improvement in 80 percent of children with congenital heart disease.

Table II

## EXPENDITURES FOR CRIPPLED CHILDREN'S SERVICES

### Reported for Fiscal Years 1954–58 and Projected for Fiscal Years 1965 and 1970

| Year | Amount (dollars) [1] | | | Average amount per child (cents) | | | Estimated civilian population under 21 [2] |
|---|---|---|---|---|---|---|---|
| | Total | Federal | State and/or local | Total | Federal | State and/or local | |
| 1954 | $36, 136, 251 | $11, 081, 792 | $25, 054, 459 | 59 | 18 | 41 | 60, 873, 000 |
| 1955 | 39, 884, 931 | 10, 821, 280 | 29, 063, 651 | 63 | 17 | 46 | 62, 834, 000 |
| 1956 | 43, 610, 859 | 14, 928, 641 | 28, 682, 218 | 67 | 23 | 44 | 64, 715, 000 |
| 1957 | 48, 561, 384 | 15, 203, 556 | 33, 357, 828 | 73 | 23 | 50 | 66, 000, 000 |
| 1958 | 52, 660, 949 | 15, 311, 930 | 37, 349, 019 | 76 | 22 | 54 | 69, 000, 000 |
| 1965 [3] | 100, 076, 400 | | | 120 | | | 83, 400, 000 |
| 1970 | 152, 295, 000 | | | 165 | | | 92, 300, 000 |

[1] Source: For fiscal years 1954–58, Joint Financial Report Form 11.1

[2] For 1954–57, estimates are those used in apportionment, as prepared by the Bureau of the Census and the Children's Bureau. Estimates for 1958 are from Bureau of Census, P–25, No. 193, adjusted to include Territories and possessions (+2.4 percent).

[3] 1965 estimates calculated Apr. 10, 1959.

The number of children with congenital heart disease receiving care in the crippled children's program increased from 2,200 in 1950 to more than 12,000 in 1958—from 1 percent of the total caseload to 4 percent—and we are probably just at the beginning of the rise in request for services.

The waiting lists at the few hospitals doing open-heart surgery are long, and they grow longer as more babies are born with conditions requiring this operation, for the number of patients that can be accepted for surgery each week is small. While the number of hospitals doing open-heart surgery is slowly increasing, more than one-half of the States as yet do not have hospitals adequately equipped and staffed for this purpose. The Association of State and Territorial Health Officers recently adopted a resolution urging State health departments interested in obtaining services for children with congenital heart disease to consult the American Heart Association's "Standards for Centers Caring for Patients With Congenital Cardiac Defects." [8]

The cost of care for children with congenital heart disease makes considerable inroads in the financial resources of State crippled children's agencies. In a number of States this has led to a depletion of crippled children's funds before the end of the fiscal year, so that in 1959 Congress made a supplemental appropriation of $1,500,000 to be used only for services for children with congenital heart disease.

In at least one large State the health department pays for 80 to 90 percent of the open-heart surgery done in the State. This is an excellent expression of what is probably one of the basic reasons for the existence of State crippled children's programs—making available to all children the productive results of years of research.

### *Looking Ahead*

A review of the progress made in services for crippled children over the past 25 years suggests that the future will bring the following developments:

- Further broadening of the definition of "crippling" until all State crippled children's programs will serve children with any kind of handicapping condition or long-term illness.
- Closer ties with maternity care services to increase the effectiveness of early casefinding of handicapped infants.
- The removal of unreasonable barriers to eligibility for services such as State requirements for court commitment, residence status, and means tests which do not reflect the great variations in the cost of medical care.
- Extension of the programs to urban areas. The need is indicated by the fact that hospitals in large cities are increasingly requesting full payment for all patients.
- Changes in the design of pediatric inpatient departments reflecting the changes taking place in the diagnostic composition of inpatients, new con-

cepts of diagnosis and care, and knowledge about the effects of hospitalization upon children.

- The development of new standards for outpatient and inpatient care.
- The development of outpatient centers for handicapped children which are organized and staffed to provide the comprehensive services needed by children with all types of handicapping conditions, thus bringing together the services presently being provided in many separate clinics.
- The development of home care programs for the aftercare of hospitalized children and for the care of homebound children.
- The development of inpatient and outpatient facilities appropriate for adolescents.
- The increased use of psychiatric services and greater attention to the social and emotional aspects of handicapping and long-term illness.
- The provision of special services for children who are both deaf and blind.
- Increased coordination of medical care, special education, and vocational counseling.
- The coordination with teaching and research centers of multidisciplinary services for children with multiple handicaps.
- The development of demonstration centers for the early care of children with paraplegia and quadriplegia brought about by accident or disease.

An intimate relationship must exist between the maternal and child health and crippled children's programs if they are to achieve their objectives. The increasing problems emerging in the crippled children's programs make it necessary to look to the maternal and child health program for help in prevention and early casefinding. Thus may be prevented the handicaps imposed on some children by prematurity birth, congenital malformations, exposure to radiation in utero, Rh incompatibility, metabolic disorders, poor nutrition of their mothers during pregnancy, their mothers' attitude toward pregnancy or toward themselves, or other factors. This underscores the importance of extending and improving the basic preventive health services for mothers and children.

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[7] Handler, Philip: *In* Hearings before the Subcommittee on Labor and Health, Education, and Welfare of the Committee on Appropriations, U.S. Senate, 86th Cong., 1st sess., H.R. 6769. 1960.

[8] Report of the Subcommittee on Education and Standards in the Field of Congenital Heart Disease: Standards for centers caring for patients with congenital cardiac defects. *Circulation*, April 1956.

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Perhaps the most serious of all the consequences of the personnel shortage is the inadequate service provided the more than 2,140,000 children in the 745,000 one-parent families who are supported by the Aid to Dependent Children program . . . Public condemnation [of the program] has come about in great part because many of the mothers who constitute the parents in these families have themselves come from deprived homes and do not always conform to approved behavior patterns and, more often than not, need the most professional help of well-qualified social workers if the vicious cycle is ever to be broken and these children are to have a chance at happiness and normal productive lives. Ironically, this is the area needing the greatest skill where the fewest number of professionally trained social workers are to be found.

*Ernest F. Witte, Executive Director, Council on Social Work Education, to the 1960 White House Conference on Children and Youth.*

# CARE OF THE MENTALLY RETARDED IN SWEDEN

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THE NEED for care and training of mentally retarded children and adults poses for each society problems in which the basic concepts of public responsibility for all its children, on the one hand, and protection of its weaker members of whatever age, on the other, are paramount. Pearl Buck has observed that a civilization can be largely judged by its attitudes toward these questions. Inevitably these attitudes express themselves first in the legal and judicial protection afforded to the individual, and secondly in the types of services which may be provided by law at public expense, of which free public education for all children is an example.

In the United States, although the foundations of law as well as the majority of social institutions stem from the British tradition, there is a close kinship with the philosophy of the Scandinavian countries where there is also interest in the rights of the individual and belief in equality of opportunity. It is not surprising, therefore, to find in the United States and Sweden many parallels in the histories of concern for the mentally deficient. Today several States of the United States have legislative commissions studying the legal status of the individual who is mentally retarded and in need either of special training or of guardianship. Such studies inevitably involve examination of the structure of the various governmental agencies which could have responsibility for providing services to the retarded. In 1954 the Swedish Parliament enacted a major revision of the national laws pertaining to both these facets of the problem of mental retardation.

Sweden is divided into 24 Provinces and 6 independent cities. In regard to services the independent cities have the same status and responsibilities as the various Provinces. The population of Sweden is somewhat more than 7 million, the Provinces having on the average about a quarter of a million people each. The Province of Stockholm, which excludes the independent city of Stockholm, has a population of about 400,000, whereas the city itself has a population of a little over 800,000. Thus from the point of view of the population base it is fair to draw an analogy between the country of Sweden and its Provinces, on the one hand, and one of the more populous States of the United States and its counties, on the other. From a political point of view the analogy is also useful, since most of the health, education, and welfare responsibilities which in the United States are vested in the State governments are in Sweden a function of the National Government. For this reason it should cause no confusion if in this discussion we adopt the European custom of referring to a national government as "the state." As in a State of the United States, the state may in some instances carry out its responsibilities directly, and in others it may delegate them by mandate to a political subdivision— in Sweden, a Province or a municipality—the state retaining the responsibility for establishing and maintaining standards of service.

## *Functions of the State*

There are ten departments in the Swedish National Government, two of which are particularly concerned with the mentally retarded—the Department of Interior and Health and the Department of Education and Religion. The Department of Interior and Health previously was a part of the Department of Social Welfare. About 10 years ago the Department of Social Welfare was reorganized, and the responsibilities for the mentally deficient were transferred to the Department of Interior and Health.

Before 1944 the problem of mental retardation was regarded solely as a medical problem. That year the Swedish Parliament enacted a law emphasizing the importance of the educational aspect of help to retarded persons, and transferring the major responsibility for services to them from the Royal Board of Medicine, Department of Interior and Health, to the Royal Board of Education, Department of Education and Religion. Under the new law enacted in 1954 the responsibility for programs for the retarded is divided between the two boards, the Royal Board of Education and Religion having the principal responsibility for directing their education and the Royal Board of Medicine for directing the medical and protective care. The combined service is lodged in the Department of Interior and Health.

### *Scope of Provincial Authority*

The 1954 law placed the principal responsibility for actual education and care of the mentally deficient in the Provincial government, which is required to establish a "central board" for the administration of the program. There are certain exceptions to this delegation of responsibility. In principle, the state retains responsibility for the mentally retarded who have seriously complicating conditions such as blindness, deafness, or severe behavior disorder, providing separate institutions for them. For the defective delinquent, for example, there are two state institutions and two state-supported, state-supervised private institutions. The state is also expected to take responsibility for the very destructive or disturbed, and the most severe cases. In practice, however, this provision has been interpreted to require the Provincial authorities to provide interim care for such individuals while waiting for placement in a state institution or elsewhere.

With the exceptions noted above, the Provincial authorities are expected to take responsibility for mentally retarded children and adults of all ages. The definition of "mentally retarded" in Sweden, however, does not include the uppermost educable group or "slow learners." The dividing line generally speaking is an IQ of 65 or 70. The slow learners—children with an IQ of 65 or 70 up to 80 or 85—are educated in special "help classes," which are a part of the regular public schools, operated by local school boards much like those in the United States.

The Provincial central board for the mentally deficient has responsibility for those retarded children of preschool age who, for one reason or another, cannot be cared for at home, for children of school age who are not eligible for the "help classes," for young people of postschool age, and adults who are not socially competent. For the state or Provincial services any person "registered" as mentally deficient is eligible without fee, regardless of his financial circumstances.

A physical therapist and her patient working together in a Swedish home for severely retarded children of school age.

Each Provincial governing body must establish a central board for the education and care of the mentally deficient and also submit a plan for approval by the appropriate agencies of the National Government of Sweden for schools, institutions, and extramural care. Two or more Provinces may combine their services. With respect to the division of authority and administrative responsibility, the relationship between the state agency and the Provincial boards responsible for the mentally retarded in Sweden is not unlike the relationship in the United States between State departments of education or of welfare and local boards of education or county welfare boards, except that in Sweden there is a somewhat higher degree of state control over standards than is usual in the United States.

### *Legislative Provisions*

There are two major principles around which Sweden's legislation for the retarded is centered. The first is that no child should be placed in an institution unless there is absolutely no possibility of his remaining either in his own home or in a suitable foster home. For the child who cannot remain in his own home the central board is required to secure

foster family placement if at all possible. The second principle is that a strong distinction exists between the educational program and the protective care program, though there is administratively little distinction between the residential and the day programs in these areas.

The law provides that the Provincial central board shall appoint a director of the educational program and a director of the care program. It sets up certain qualifications for each of these positions and it further provides that the director of the educational program may also have responsibility for the care program, but not vice versa. The majority of Provinces take advantage of the opportunity to combine the two programs under one director, an educator.

### *Facilities*

In Sweden a child is eligible for a special school program if he has an IQ somewhere between 35–40 and 65–70. When the child has been so classified, he must attend a school. He is subject to compulsory attendance from the age of 7 to at least 16, and thereafter up to the age of 21 at the discretion of the director of the program and the central board as described later. The expenses, whether for day or residential school or for foster care, are entirely borne by the public.

The emphasis is on day schools. Special day classes may be set up within the public schools by arrangements between the Provincial central board and various local school authorities. When such arrangements are made, there may be an agreement between the director of the educational program for the retarded and the school principal or superintendent concerning the supervision of these classes. However, the ultimate responsibility for supervision always rests with the director. Special day schools may be established under the supervision of the director, and day classes may also be set up in any residential institution for children who live near the institution. The law requires that any community having a total population of 25,000 or more shall have access to a day program. Such day programs may be provided in the community itself or in an adjacent area which is accessible to the children.

The law also provides that separate units (under a single administration) shall be provided of the following types:

1. Adult occupational residence centers. These are for the adults who may have been educated in the special schools or classes but who are not capable of handling themselves in the community. The law specifically requires that they be given work to do to be kept occupied.
2. Residential old-age centers. The age at which "old age" sets in is not specified, but generally speaking these institutions are for the accommodation of individuals who may have been in the occupational residence centers or in extramural placement (own family or foster family) and are now too old to work.
3. Child care homes. These are for children who are not eligible for schooling. Simple self-help and sense training, physical and speech therapy are provided as appropriate.
4. Institutions providing residential care for adults. These are for the same individuals later in life. By law children and adults must be separated in the care program. As a result, in some Provinces the care homes for children under the "care" program have been placed near the residential schools for children rather than near the centers for residential care of adults.
5. Day care centers for children over 4 and adults who are living in the community and not attending any other school program. Suitable occupational activities must be provided in these centers.

### *Admissions and Discharges*

The general principle behind the admission and discharge procedure is that enrollment in the school program is compulsory for eligible children of school age, but enrollment in all other programs is voluntary. A child who is not subject to compulsory school attendance may be placed away from home without the consent of his parents only when the usual judicial proceedings, applicable to children generally under the child welfare code, have been instituted and where the guardianship of the child has been transferred from his parents to the board of child welfare. The circumstances under which this is possible are comparable whether the child is of normal or of retarded mentality.

In general, it is expected that parents will take the initiative in applying to have their children "registered" as mentally retarded. If a child is of school age and is thought by the authorities of the regular schools to be eligible for education in the special program of the central board for the mentally retarded and the parents fail to apply, the schools are obliged to see that an application is filed. In any case the parents are required to state in

writing whether or not they concur in the application. When a child is "registered" it becomes the Province's responsibility to provide for him through its central board.

The board's first responsibility is to determine in what part of the program the child should be placed. If the parents concur in the application and proposed plan, there is no need for judicial proceedings. If they do not agree to the proposed plan, then a special committee headed by a judge and composed of from two to four members of the central board adjudicates the issue, after reviewing all the evidence. This committee must also be available to review transfers from the school department to the "care" department.

When a child who has been in the school program reaches the age of 16, the director must determine whether or not he may be discharged or should continue in the school program, and if continued whether this be in its day or residential aspect. The reasons for the director's decisions must be noted in the pupil's cumulative record. If 2 years later the director thinks that the boy or girl should still be continued in the school program, he must present his reasons to the special judicial committee, which makes the final decision. The case comes up for review again each year thereafter until the young person is 21. Compulsory school attendance is thus absolute for most children with IQ's over 35 or 40, from age 7 to 16, and in individual cases may be continued at the discretion of the authorities to the age of 21. Under unusual circumstances a mentally retarded person may be kept in school until the age of 23, but this is not customary.

If when a mentally retarded person reaches 21 he is not capable of managing himself in the community, the director has the responsibility of seeing that guardianship proceedings are instituted. The guardian appointed may be one of the natural parents or not, as circumstances indicate. Each community has an official "chief guardian" who is responsible for verifying the guardianship status of mentally retarded persons in the community from year to year.

Since in Sweden there is an annual compulsory registration of all citizens, it is possible for the authorities to obtain pertinent information about every child and thus to maintain better statistical control than is generally found in the United States.

An attendant in a home for retarded preschool children in Sweden teaches a child with cerebral palsy to ride a bike.

### *Procedures for Classification*

When an application is to be made for a child to be "registered" as mentally retarded, whether for the school program or the care program, certain forms, including a record of medical and psychological examination, must be completed. In most cases the medical and psychological examination is made at the child guidance center in the Province, where a qualified child psychiatrist sees the child. Subsequently both the director and the psychiatrist of the central board's educational program must concur in the proposed plan for the child. If they disagree, the matter must be referred to a special judicial committee even though the application may have been a voluntary one. Under the law the central board's child psychiatrist cannot be the examing doctor who supports the application, since the same doctor cannot act as both proponent and reviewer of the case.

In general, applications for registering children for protective care are voluntary on the part of the parents. The only exceptions are the cases in which the child welfare board has seen fit to intervene. In such a case the child welfare board must first obtain jurisdiction over the child. Then it may act in loco parentis in applying for admission of the child to the services of the central board for the mentally retarded for either day-care, foster-family, or residential placement.

The law also provides for trial placement of

Boys doing metalwork in a Swedish school for the retarded.

children for observation up to 6 months, or in special cases up to 1 year. Children so placed are not considered to be "registered" until a final decision has been made. This provision makes rapid placement of children possible in case of an emergency in the family such as a parent's death.

If it is decided to transfer a child from the educational to the care program, the procedures must be instituted anew, practically on the basis of a new admission. A child can be transferred from the protective-care to the educational program by the director, with the physician's approval, without renewed application.

It is important to note that with the exception of mentally retarded persons subject to the compulsory school-attendance laws—that is, those considered educable, between the ages of 7 and 16—there is at all times the opportunity for a parent or guardian or even the mentally retarded person himself to arrange for discharge from the school or care program. Even the severely retarded adult has a guardian other than the authority operating the program. So far this provision for voluntary withdrawal of a child or adult from the program by his parents or other guardian has rarely been misused either to the disadvantage of the child or of the community.

Parent counseling for parents of children of preschool age as well as older children is provided at child guidance clinics associated with provincial hospitals. The parents' organization cooperates in counseling and advising parents on the home care of young and very severely retarded children. Thought is being given in the Province of Stockholm to inaugurating a more formal home training program with well-qualified visiting teachers, who would each assist about 20 families.

A well-supervised foster home program for children of all ages is already underway.

### *Basic Program Concepts*

In visualizing the application of all these provisions it is important to bear in mind that everything is done on a smaller and more intimate scale in Sweden than in the United States. For example, the Province of Stockholm has less than 600 institutionalized children and they are divided among 4 separate institutions, 1 a residential school and 3 custodial homes for protective care. A dozen children in one cottage or home living unit is considered a large number. Swedish visitors, as well as visitors from Japan, Holland, Great Britain, and elsewhere, have observed that the vast American institutions, with some "cottages" housing a hundred or more children, are incompatible with their concepts of human dignity and of the principles of good child care.

Whereas in the United States the trend has been away from county responsibility in the institutional field as being inefficient, in Sweden small units, close to the citizenry served and locally administered, are looked upon as desirable. The evils of lower standards, fear of which leads many in the United States to advocate concentrating operational responsibility at the State level, are combated in Sweden by firmer imposition of state standards for Provincial (county) programs, combined with a greater emphasis on and acceptance of public, as distinct from voluntary, responsibility for care of the afflicted, regardless of the family's economic status. This point of view apparently makes possible the expenditures needed for the construction and appropriate staffing of small living units and schools and the provision therein of a high quality of professional service at per capita cost greater than would be tolerated in the United States at the present time.

# NO HOMES OF THEIR OWN

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FEW OTHER human circumstances have the appeal of the plight of a homeless child—if the circumstances are dramatic enough to engage the attention of the press, and if the child is sufficiently attractive to the public eye. The fact that large numbers of people can be aroused to sympathy for a child without a home or family is encouraging, for it expresses a depth of human sympathy and warmth that might be enlisted in support of better services for children. Too often, unfortunately, the interest aroused by a dramatic incident subsides, and the attention of a busy populace is focused on new problems.

Meanwhile, what of the one-quarter million children who are living in foster care whose situations do not come to the attention of the public? What chance have they for homes of their own, either through return to their parents or through adoption? In their report, "Children in Need of Parents," Henry S. Maas and Richard E. Engler[1] note that some of these children grow up in foster care, some shift frequently from foster care to homes of parents or relatives, and back again, and a small proportion are adopted. They report: "For most, the foster care experience will stretch across months, even years, of a crucial period in their lives."

People with a deep conviction that children need and have a right to permanent homes of their own are quite naturally moved to ask why this should be. Many questions might be asked, and many possible explanations might be offered. Is it the fault of the social agencies? Are they too slow to act? Are they too entangled in redtape? Or is it the fault of courts? Is our judicial system too cumbersome to permit more frequent adoptions?

Perhaps the answers are to be found in the way we live today. Are we encouraging irresponsibility on the part of parents, who find it too easy to reject and discard their children? On the other hand, are we too slow to take children from the custody of indifferent parents? Or could the trouble be attributed to the kinds of children in foster care? Are their homes so untenable and their personalities so marred that there can be no better plan for many of them than continuing or intermittent foster care, with all of its impermanence and insecurity?

Are our social agencies doing their job? Are they cooperating with other social agencies? With the courts? With law enforcement agencies? Do they have enough staff? Are the members of their staffs adequately trained for their jobs?

The number and range of questions that the Maas and Engler findings provoke indicate that there is not likely to be any single, simple answer to the problem of children without homes. Obviously we need less speculation and more facts if we are to find better ways of meeting the needs of these children. While there has been considerable gathering and reporting of facts over the past few decades from national, State, and local agencies, there has been a dearth of organized, systematic, scientific inquiry of a comprehensive nature to fit the facts together into a clear picture.

It is also quite likely that local characteristics of deep significance in the study of this problem may be submerged in State, regional, or national reporting. Do some kinds of communities have more of a child care problem than others? If so, is there any connection between this and the ethnic background of the people in the community? Is it affected by the extent of migration in the community? Do the community's industrial characteristics have anything to do with it?

Some of these questions are answered for specific communities in the Maas and Engler report. While the answers may not apply to all communities, they at least are disturbing enough to indicate that no community can afford to neglect taking a long and deep look at what is happening to those of its children who have been separated from their parents.

"Children in Need of Parents," as its title suggests, is a study of children in foster care. It is not a heavy, methodologically impeccable treatise. Neither is it a journalistic excursion into child life in American communities. To treat it in either light would miss the point. It offers findings and hypotheses, not conclusions. But in testing these hypotheses, communities quite probably would find many opportunities to improve the scope and quality of their services. They might very well as a result of mobilizing for this purpose find it possible to give many children a better chance in life.

The major objectives of the study, as stated by the authors, were: "(1) to secure information about children in foster care in a variety of American communities; and (2) to make this information available both to the general public and to participating and related communities to stimulate thought and action toward modifying or changing conditions as indicated." The task was undertaken by two research "teams," each of which consisted of a child welfare worker and a sociologist. The nine communities selected ranged in population density from rural counties to large cities and were in various parts of the country.

### *The Children*

Social agencies, so-called "key persons" in the communities, and the legal systems were all sources of information. But, as the authors note: "Seen and described in these social contexts, the dependent children remain the central figures in our story. It is their characteristics, and those of their parents, and their placement experiences which are the heart of our report. . . ." The investigators sought information on the children which would shed light on their chances of getting a permanent home. They were concerned with the interaction of individual and sociocultural factors which would affect the child's chances. Was a child handicapped by physical disability, or mental slowness, or of mixed ancestry, or socially handicapped by "sporadically appearing and disappearing parents"? Was he likely to have a better chance in a community where his ethnic background is less important than his basic humanity and his need for parents, or where it makes him a member of a majority instead of a minority?

Nine communities—urban, rural, ethnically homogeneous, and ethnically heterogeneous—were examined in the search for ways in which distinctive social pressures determined the fate of a dependent child. These communities were paired according to size with the exception of the ninth or "test" community. The pairs included two rural communities, two small urban communities, two metropolitan areas, and two big cities. The communities in each pair had some contrasting characteristics—in population composition, traditions, economic situation, or ways of handling problems.

In each instance the reader is first introduced to the children. Individual children are described as well as the general characteristics of others in foster care. The features of the community which operated for or militated against the making of permanent plans for the children are pointed out.

The study took the "teams" into an analysis of placement processes, of legal systems and legal roles; into an appraisal of how well networks of agencies serve the children, into study of adoption prospects and processes; into study of the children and their parents. Among the influences on plans made for children described are: the attitudes of judges toward children's rights compared with parental rights; whether the community traditionally provides child care under sectarian or nonsectarian auspices; whether the prevailing tendency is to provide for long-term foster care or to make efforts to encourage movement of the child into community life; patterns of agency care; degree of staff professionalization; degree of communication among agencies serving children; and many other factors of evident importance to the child's chances.

The report indicates that a community's size influences the way people live and relate to each other, individually and in groups—their degree of warmth or impersonality in human relations, their retention or loss of group identification, and the cohesiveness or segmentation of the population as a whole. It shows how these effects in turn affect the care of dependent children.

As the authors approached "The Summation and Test" in their study of the ninth community, they had already developed the hypothesis that "foster care placements reflect the normal social process tendencies in the culture of a community." They followed this hypothesis with several of a more specific nature. These last relate the community's orien-

tation to its degree of concern for children needing care away from home as well as to its use of institutional as against foster family care. They also identify community forces and influences which seem to operate for or against adoption. These and many other observations and hypotheses suggest a rich field of inquiry.

### *Their Chances*

How does it all come out? More than half of the children studied face the bleak prospect of living in foster care for most of their childhood. The authors point out what this means: "Children who move through a series of families or are reared without close and continuing ties to a responsible adult have more than the usual problems in discovering who they are. These are the children who develop shallow roots in relationships with others, who try to please but cannot trust, or who strike out before they can be let down."

The behavior of the parents toward the children in foster care was found to have predictive significance in relation to the children's chances for getting back home. The "unvisited," that is, those ignored by their parents, had little chance. The "visited," those whose parents showed concern and gave the children some attention, had a much better chance. Then there were the "relinquished," those who had been or were about to be relinquished by their parents for adoption.

What about the prospective adoptive parents? In the characteristics of these couples, in their attitudes, their hopes, and their prejudices, their personalities and life circumstances are to be found a wide range of acceptability of children. From their studies in the nine communities, the authors developed a modal couple in the various communities. These variations offer more hope for many children than does the modal couple, especially for children who are past the toddler age, or who are handicapped individually or socially. But the picture as a whole is not a bright one for children who are not normal, healthy infants with a nationality or racial background corresponding to that of prospective adoptive parents.

Maintaining that potential opportunities for adoption exist for those children who do not now have much of a chance, Joseph H. Reid, executive director of the Child Welfare League of America, in a final chapter of the report presents directions for realizing them:

Professional workers must make greater effort to reach prospective adoptive families for these children. They must find ways of communicating more effectively with major segments of the public. They must look with critical realism on the ways their own regulations are affecting the hard-to-place child. They must strengthen licensing procedures for long-term foster care and undertake research into those factors in a foster family which promote emotional health. Communities must provide more effective control of child caring agencies. Laws to strengthen and clarify measures for the protection of children should be enacted, and legal deterrents removed.

Studies are needed as a basis for such action, Mr. Reid points out, especially studies which reveal both deficiencies and achievements of child welfare programs. He also advocates preventive measures to identify and treat family stress before breakdown occurs.

These are only some of the steps that Mr. Reid urges, but they provide an indication of the study's far-reaching significance.

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[1] Maas, Henry S.; Engler, Richard E.: Children in need of parents. Columbia University Press, New York, 1959. $7.50. 462 pp.

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It is no problem for a community to show concern for the likeable and responsive, but to build a true and universal sense of community acts of concern must also embrace the exiled, the disinherited, and the disenchanted, who are slow to respond and suspicious of our motives.

*Bertram M. Beck, Associate Executive Director, National Association of Social Workers, to the 1960 White House Conference on Children and Youth.*

# BOOK NOTES

THE SELF-IMAGE OF THE FOSTER CHILD. Eugene A. Weinstein. Russell Sage Foundation, New York. 1960. 80 pp. $2.

Tentative answers to the question, "What does foster-family care do to a child?" are presented in this account of a study of a sample of children living in boarding homes under supervision of a child-caring agency. The author, who is associate professor of sociology at Vanderbilt University, studied the case records of 61 children and interviewed each child. He found that when the natural parents kept in contact with the child the detrimental effects of long-term foster care were lessened; that the children in foster care who identified more closely with their natural parents than with their foster parents rated highest in "well-being," according to measurements developed by Howard R. Stanton; and that the more clearly the children understood the meaning of foster care and the part the agency played in it, the better was their adjustment.

SOCIAL WORK YEAR BOOK 1960; a description of organized activities in social work and in related fields. Fourteenth issue. Russell H. Kurtz, editor. National Association of Social Workers, New York. 1960. 767 pp. $8.50.

Part 1 of this encyclopedia of the social services consists of three articles on the development, status, and trends of social welfare and social security programs in the United States; part 2, of 68 topical articles on the various types of services which have been developed to meet human needs and the methods through which they are carried out; part 3, of four directories of agencies—international, national governmental, national voluntary, and Canadian.

This edition, the first since 1957, is the second published under the auspices of the National Association of Social Workers. Topics included that did not appear in the 1957 edition are: "Community Development," "Labor and Social Welfare," and "Narcotic Addiction." The other articles have either been completely rewritten or revised to include recent developments.

CHARACTER DISORDERS IN PARENTS OF DELINQUENTS. Beatrice Simcox Reiner and Irving Kaufman. Family Service Association, New York. 1959. 179 pp. $2.75.

On the theory that successful treatment of juvenile delinquents often implies understanding and treatment of their parents, this book presents a four-stage method of treating adults having "impulse ridden character disorders," a diagnosis, the authors suggest, applicable to the parents of many delinquents. The presentation is based on a 5-year study of the treatment of 17 parents of juvenile delinquents—14 women and 3 men. The clients are classified psychoanalytically according to type of fixation; and the import of the classification to treatment clearly indicated.

Short-term therapy can do little for such clients, according to the authors, a social caseworker and a psychiatrist. They see any lasting change in the client's personality as dependent upon the client's achieving the objectives of each treatment stage: establishing a relationship with the caseworker; identification with the caseworker; establishing a separate identity; understanding the roots of his own behavior.

EDUCATION FOR CHILD REARING. Orville G. Brim, Jr. Russell Sage Foundation, New York. 1959. 362 pp. $5.

From the viewpoint of the sociologist, says the author of this analysis of parent-education programs, parent education is "a systematic attempt to change the social requirements and performance of one of the major roles in modern society—namely, that of the parent." In the study he attempts to show what the social sciences have already contributed to the theory and practice in this field, to suggest what they could further contribute, and to "analyze other issues in parent education to which the social sciences cannot contribute significantly at this time."

Part 1 discusses (1) parent educators' assumptions about the basis of human social behavior and about effective methods of changing such behavior and (2) the objectives of parent-education programs.

Some of the assumptions concern what kinds of people parents are, why they behave as they do, and how they affect their children. The programs' objectives, the author notes, are to improve parents' decision processes, both in choice of aims in child rearing and in selection of actual child-training practices.

In part 2 the author discusses the content of parent-education programs; use of mass media, counseling, and group discussion as educational methods with parents; selection and training of parent educators; and evaluation of the effectiveness of the programs.

An appendix presents a history of education for child rearing.

The author, who formerly taught sociology at the University of Wisconsin, is now on the staff of the Russell Sage Foundation.

PSYCHOLOGY OF THE CHILD; personal, social, and disturbed child development. Robert I. Watson. John Wiley & Sons, New York. 1959. 662 pp. $6.95.

In this textbook on child psychology the author, a professor of psychology at Northwestern University, has attempted "to combine the dramatic sweep of child development with the rigor and exactitude of the research studies contributing to it."

Noting that the aim of child psychology is to increase the accuracy of predictions concerning child behavior, the author traces the historical development of attitudes toward the child and the methods of study to which these have given rise, indicating the contributions which other disciplines have made to the development of this science.

A section on present-day basic principles and concepts is followed by detailed descriptions of development, as indicated by research, in three periods: infancy, early childhood, and later childhood. There are comprehensive reference lists at the end of each chapter.

THE DISTURBED CHILD; recognition and psychoeducational therapy in the classroom. Pearl H. Berkowitz and Esther P. Rothman. New York University Press, New York. 1960. 204 pp. $4.

Written for teachers of normal children as well as teachers of emotionally disturbed children, this book stresses the importance of recognizing emotional disturbance early in life, describes behavioral symptoms of serious disturbance, and briefly discusses the causes and manifestations of a number of types of personality deviation—schizophrenia, diffuse organic malfunctioning, neuroses, acting-out behavior patterns, sexual deviations, and psychopathy.

The book suggests ways for dealing with an emotionally disturbed child in the classroom, whether the child is the only disturbed child in the class or a member of a special class for emotionally disturbed children. Other subjects discussed are: clinical assessment of a child's personality, building confidence in a disturbed child through creative artistic expression, and adjusting the academic curriculum to an individual child. Included is a transcript of a classroom session in a psychiatric hospital.

Both authors are psychologists and educators; Dr. Berkowitz teaches at the Bellevue Hospital school in New York and Dr. Rothman is principal of one of New York City's "600" schools for children with behavior problems.

# International Publications

REPORT OF THE FAO UNICEF REGIONAL SCHOOL FEEDING SEMINAR FOR ASIA AND THE FAR EAST; Tokyo, Japan, November 10–19, 1958. FAO Nutrition Meetings Reports Series No. 22. Food and Agriculture Organization of the United Nations, Rome, Italy. 1959. 51 pp. $1. For sale by Columbia University Press, International Documents Service, 2960 Broadway, New York 27.

The discussions reported in this publication note the role of the primary school in improving children's nutrition and general health and recommend that school nutrition programs be coordinated with other nutrition work in the community. The report recommends guidelines for a school feeding program and stresses the importance of periodic assessment of such programs. It also recommends that school nutrition programs include not only school feeding but also school gardening and education in nutrition; and that countries with programs now helped by UNICEF and CARE should plan for continuing the programs with resources available within the country.

Among the report's recommendations to international organizations are: that FAO, WHO, and UNICEF convene a meeting to consider nutrition problems of preschool children and children of school age not attending school, and that the three organizations provide assistance to countries desiring to conduct trials of the acceptability and use of locally produced foods, including those from school gardens.

CONQUERING PHYSICAL HANDICAPS; official proceedings of the First Pan-Pacific Rehabilitation Conference, held in Sydney, Australia, November 10–14, 1958. Australian Advisory Council for the Physically Handicapped, Sydney. 1959. 591 pp. For sale by International Society for the Welfare of Cripples, 701 First Avenue, at 40th Street, New York 17. $3.

This report of a conference on rehabilitation, held under the auspices of the International Society for the Welfare of Cripples, includes contributions from representatives of such disciplines as medicine and surgery; orthopedic and industrial nursing; physical, occupational, and speech therapy; education and psychology; vocational counseling; hospital management; and prosthetics. The conference was at a dozen nations and from international groups, including the United Nations Organisation, United Nations Children's Fund, and the International Labour Organisation.

Among the subjects of the papers are: the congenital amputee; group recreation for physically handicapped children; building independence through therapy and education; social aspects of rehabilitation; stammering; and care of the cerebral palsied.

YOUTH AND WORK. Part 1 of Report 1 of the Director General of the International Labor Organization. International Labour Conference, 44th Session, Geneva, 1960. International Labour Office, Geneva. 1960. 119 pp. For sale by International Labor Office Washington Branch, 917 15th Street NW., Washington 5, D.C. $1.

This report discusses the economic and social factors influencing the environment of young workers today, including population growth, technological change, migration from rural to urban areas, poor housing, and breakdown of traditional forms of family and social life.

The report discusses the specific opportunities needed by young workers: a general educational foundation; job with good conditions, jobs satisfying to the young persons and useful to the community; continued development while employed; health care; leisure time; ways of participating in community affairs and social causes.

The main part of the report concerns boys and girls 15–19 years of age, but a chapter is included on children under 15 in the labor force, chiefly in undeveloped countries. This maintains that the basic difficulties in abolishing child labor are family poverty and lack of schools.

The report includes the text of the United Nations Declaration of the Rights of the Child, and a statement of the Basic ILO Standards for Youth.

# HERE AND THERE

## *Nursing Services to Mentally Retarded*

Some 40 public health nurses who work in diagnostic and evaluation centers for mentally retarded children throughout the Nation met for 3 days at the Children's Bureau in Washington late in May to share reports of progress, to consider mutual problems, and to develop tools to improve their services to the children and their families.

This meeting was a sequel to one held in Washington 2 years ago when the nurses first came together to explore their role as team members in the newly organized centers.

The discussions at this year's meeting revealed how the contribution of the nurse on the diagnostic and evaluation center team has broadened to encompass service to the family as a whole. Case material presented showed how the public health nurse visiting a family of a retarded child also helped other members of the family obtain needed health services through referrals to appropriate community resources. The importance of correlating nursing services in mental retardation centers with those of State and local health services was especially emphasized, with a variety of methods for doing so being suggested.

The nurses also discussed the need for research in various aspects of providing nursing service to families of retarded children. Two studies on the numbers of mentally retarded children served by local public health nurses were reviewed.

Several nurses reported on their success in working with parent groups, such as a local association for retarded children. These reports stimulated discussion of the opportunities that arise for the public health nurse in mental retardation programs to contribute to various aspects of nursing education, especially through staff education programs in local health services, the organization and conducting of statewide nursing institutes, and the provision of consultation on mental retardation to pediatric nursing instructors in schools of nursing.

The participants spent a major portion of their time at the meeting in working in groups on four projects they had previously selected as areas of interest. These were: (1) the compilation of suggestions for educational experiences for nurses caring for mentally retarded children; (2) the development of a technique to assist public health nurses working with parents of mentally retarded children in difficult feeding situations; (3) the compilation of suggestions for group activities with parents of mentally retarded children; (4) the development of a teaching tool to assist public health nurses with instruction in child growth and development.

Each group prepared a work outline to be developed further by the participants while they are on the job. The groups plan to continue as four working committees, keeping in touch by mail and completing their selected projects in about 6 months. Each project when completed will be made available to public health nurses throughout the country who are interested in serving families of mentally retarded children.

Miss Marjorie J. Martin of the Developmental Evaluation Clinic, Miami, Fla., was selected by the total group of nurses present to be its liaison with the National Technical Committee on Clinic Programs for Mentally Retarded Children.

—Eleanor F. Hawley

## *Radiation*

All exposure of people to ionizing radiation beyond that from the natural background should be reduced to the lowest practicable levels, and action toward such reduction should not be deferred, says the National Academy of Sciences, which recently issued the second report of its six committees on the biological effects of such radiation. The first report was issued in 1956. (See "Safeguarding Children from Radiation Risks," by Robert W. Miller, M.D., CHILDREN, November–December 1956).

No drastic revisions of their earlier recommendations have been made by the committees, but they stress greater attention to future objectives in the study of biological hazards and to research programs needed to attain those objectives.

In the absence of further information on mutation rates in relation to dose rates of exposure, the committee on genetic effects of atomic radiation continues to recommend that for the general population the average gonadal doses accumulated during the first 30 years of life should not exceed 10 roentgens of man-made radiation and should be kept as far below that as is practicable; but it points out that "from a genetic point of view there appears to be no threshold level of exposure below which genetic damage does not occur." Its report favors "erring on the side of caution," as the effects of increased exposure will continue through many generations.

This committee urges two general types of investigations: (1) those needed for improving estimates of exposures from given practices and their consequences; (2) those designed to extend our fundamental knowledge of mutation and its effects. In studies of the second type the committee recognizes serious difficulties because estimates of damage due to unfavorable genes are often misleading. Noting that one cannot measure quantitatively the relative importance of stillbirth, of feebleminedness, and of death in adolescence, the report nevertheless stresses the possibility and desirability of getting estimates on the relative frequencies of different types of mutant abormalities, expressed in broad categories, such as early or late deaths of embryos, infant deaths, mental defects, and sterility.

The committee also points to the importance of learning more about the possible genetic effects of nonradioactive chemical substances such as industrial and automobile fumes, tobacco, and antibiotics, and the relation of radiation-induced mutations to possible "intermediate chemical modifications of the cellular environment."

The committee on pathologic effects points out the need for more detailed and controlled studies on the effects of low doses of radiation on embryonic development. Strontium 90 with or

without radioactive iodine, which is increasingly appearing in cheese and milk in Western countries, is more likely to produce somatic than genetic damage, this committee reports. It adds that levels at which these isotopes are now appearing in foodstuffs remain at present "well below those that need to be considered cause for alarm."

Other reporting committees are those on meteorological aspects, agriculture and food supplies, disposal and dispersal of radioactive wastes, and oceanography and fisheries.

## *Against Illegitimacy*

A plan aimed at reversing the upward trends in illegitimate births, juvenile delinquency, and adult crime in Fulton County, Ga., which includes the city of Atlanta, was recently submitted to the county board of public welfare by its advisory council on illegitimacy and adoption.

Pointing to the county's past inability to combat these trends in spite of a "superb roster of social services" provided by individual agencies, the council blames this failure on lack of concerted action. Under the plan the agencies would join in providing intensive services to "multiproblem families" in two slum neighborhoods in a "war against dependence, medical indigence, and disordered behavior."

The plan includes placing in each of the selected neighborhoods a task force made up of staff members of the various agencies—social workers, school counselors, probation officers, home visitors, groupwork leaders, health personnel, and others. Each task force would be sponsored by a council of neighborhood leaders. A community welfare council for the Greater Atlanta area would set policies, supervise operations, and inform the community about successes and failures.

Suggesting that community rejection of an "illegitimate parent" or her child only leads to more serious problems, the council's report recommends surrounding the unmarried mother with "every help she will accept and use on the tough road to self-reliance and inner strength." It also urges amendments to the adoption law to discourage independent placements made under the stress of circumstances.

The report also includes a résumé of a research study of the effects of unfavorable family circumstances on the work that children do in school.

Single copies of the report, "Why not stop living with and start licking our problems?" may be obtained without charge from the Fulton County Department of Public Welfare, 165 Central Avenue SW., Atlanta 3, Ga.

## *Adoption*

That children in foster care are likely to become less adoptable as several years go by is suggested by a recent study of 100 New York State children who had been away from their parents for an average of 5½ years. (Their average age was 11 years.) The study, a pilot project planned to precede a statewide one, was made by the State Charities Aid Association. The report uses the term "adoptability" to mean having the capacity to form a relationship with new parents and to develop in a family. Factors such as race, religion, age, or physical or mental handicap, the report states, were regarded as related to the composition and attitude of the community rather than to the child's capacity.

Agency records showed that of the 93 children concerning whom consideration of their adoptability was pertinent, 35 had been judged adoptable when they were first placed in foster care and that 2 years later 33 were so judged, but by the time of the study the number of adoptable children had dropped to 12. Such change, the report maintains, emphasizes the need for constant reevaluation of plans for the child.

Only two of the adoptable children were legally free to be adopted, although nine had been separated from their parents almost from birth and none were being visited by their parents more than once a month. Of the 10 not free for adoption, the association reports that 2 might be relinquished by their parents if the latter received casework help, and that 8 could be freed for adoption only through court action. The report notes that courts are usually reluctant to approve permanent separation of a child from his parents.

Among other findings the study showed:

- That the families of a large majority of the children were so seriously deteriorated that rehabilitation was deemed impossible, and that the deterioration had been present at the time the children were first separated from their parents.
- That parents who at the time of placement demonstrated interest in their children tended to lose that interest.
- That the majority of the children had experienced substantial periods of interim care before placement, and that little attempt had been made during that time to plan the best possible future for the child.

. . .

A followup study to assess the adjustment of children placed for adoption by the Children's Aid Society of Pennsylvania between 1950 and 1957 is being carried on jointly by the agency and the Graduate Department of Social Work and Social Research, Bryn Mawr College. The agency hopes that the findings on the children and the families into which they have been adopted will help it place children for adoption with more precision and confidence.

The research workers are trying to learn the following facts about each of the 780 children involved: how he is progressing in mental, social, and personal growth; whether he has been told that he is adopted and, if so, how he was told and what were his reactions—immediately and later; what kinds of problems he encounters with other children and whether he feels different from them. They are also attempting to find out whether problems are encountered in relation to the presence or absence of other adopted children in the family or of children born to the parents; whether there is a significant relationship between age of placement and the child's adjustment; whether a child's "separation reaction" at time of adoption relates to his later development; whether the parents' attitude toward infertility has any bearing on their adequacy as parents; and how the agency's predictions in regard to the child's mental ability relate to his achievements.

The research is being carried out in three stages: (1) collection of data from agency records and of answers to questionnaires filled out by parents, the latter including parents' judgments of the child's development; (2) assessments of mental and personality characteristics of the children through direct contact with them and their parents and recording of data about the parents; (3) comparison of adopted children in school with other schoolchildren regarding, for example, educational achievement, adjustment, leadership qualities,

teachers' judgments, and extracurricular activities.

. . .

As part of an effort to find adoptive homes for older children, children in minority groups, and groups of brothers and sisters, child welfare staff members in two district offices of the Montana State Department of Public Welfare recently held a meeting with 31 couples whose applications for an adoptive child had been approved. At that time these offices had 31 children available for adoption, but only 3 of them were of the easy-to-place type; that is, infants of northern European ancestry. Some of the children were American Indians.

All members of the 31 couples who attended the meeting were of northern European background, with the exception of one person who was of southern European origin.

At the meeting each child's picture was shown on a screen, and the staff told the group about his background, his behavior, his date of birth, and, with a few exceptions, his name and his need for a home. Questions were encouraged and the couples assured that failure to take one of these children would not remove them for consideration for a child of their choice. The couples, some of whom had previously said that they were not interested in taking children of a different ethnic background from their own, now showed great interest in such children, and several asked to see certain pictures again and to have the information about the children repeated. The staff asked the couples to indicate in writing the names of the children in whom they were interested, and all but five did so.

In less than a month homes had been found for six of the children, two of them a brother and sister of mixed racial background, aged 3 and 4½, placed in the same family, and four of them infants, two of whom were of mixed racial backgrounds.

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The American College of Obstetricians and Gynecologists, through its committee on infant adoptions, has begun a broad project with other national medical groups, the American Bar Association, and the Children's Bureau, to help communities to improve their adoption practices.

Five cities—Baltimore, Cincinnati, Denver, Detroit, and Los Angeles—have been selected for pilot educational campaigns; in each a fellow of the College is joining with a social worker and a pediatrician in efforts (1) to better the relationship between doctors and social workers with regard to adoption and (2) to stimulate the community to improve its adoption practices through joint action by obstetricians, pediatricians, social workers, and the juvenile court.

After a period of about 2 years, during which the five teams will exchange reports of their results, the committee will correlate the reports and formulate recommendations to be made to other communities for improving their adoption practices.

## *School Adjustment*

In an effort to develop guidelines for future school guidance programs, a year's study has been begun by the Commission on Guidance in American schools, a group newly appointed by the American Personnel and Guidance Association. The inquiry, which is supported by a grant of $50,000 from the Fund for the Advancement of Education, will have three goals: (1) An analysis of the distinctive function of guidance in American schools during the next 20 years, taking into account expected economic, technological, and population changes that will be affecting education; (2) what a guidance program should be 15 or 20 years from now, and what part teachers and administrators will play in it, as well as special guidance workers; (3) a description of the kinds of personnel which will be needed and what kinds of education they should have to be prepared for their guidance responsibilities.

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In an effort to identify influences that contribute critically to acceptable and unacceptable behavior on the part of adolescents, the University of Southern California's Youth Studies Center is asking a number of boys and girls about their attitudes, values, self-concepts, goals, and expectations. The group studied—a sampling of the junior and senior high school students in Santa Monica—includes well-adjusted students and students with various degrees of maladjustment. Particular attention will be given to the problems leading young people to drop out of school early and to young people's employment difficulties and opportunities.

As one phase of the project, pupils in the 8th, 9th, and 10th grades are being interviewed to learn how they perceive problems of their adjustment to school and to their general social environment. The study will also include interviews with a number of young adults to obtain retrospective impressions of their adolescent experiences.

Another phase will be an experiment to learn how a program of remedial teaching, work placement, and guidance affects the school adjustment of problem students and the general social adjustment of "dropouts." Using what is learned from the experiment, the center will plan a broader use of the program described.

In another project the Youth Studies Center is seeking to understand the effective and ineffective uses of authority in dealing with adolescents by such community institutions as the schools, the police department, the juvenile court and its probation department, and recreation agencies.

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Counseling and guidance institutes established under the provisions of the National Defense Education Act will be carried on in the academic year 1960–61 by 22 colleges and universities, providing training for about 800 secondary-school teachers. In addition, 84 colleges and universities are holding short-term institutes during the coming summer for about 3,000 secondary-school teachers. Available funds do not permit establishment of an institute in each State, but attendance by enrollees from all the States has been assured.

## *Talent Study*

A census of the aptitudes and abilities of 460,000 students in public, private, and parochial secondary schools, urban and rural, in all 50 of the States was begun in March by the University of Pittsburgh as a step toward helping the students to identify, develop, and use all their talents. The study, called Project Talent, is also collecting information on each student's school guidance and educational programs, on whether he plans to enter college or other advanced training within the next 4 years, and on the field in which he plans to work. The information will be used as the basis for estimates of how many potential teachers, physicians, nurses, engineers, and other types of workers are among the stu-

dents tested, as well as how many plan to enter careers in public service and other fields.

About 20,000 teachers are collecting the information, under the supervision of 1,400 principals and 1,000 superintendens of schools.

The project is receiving its chief financial support from the Department of Health, Education, and Welfare, through the Office of Education and the National Institute of Mental Health, with contributions from the Department of Defense through the Office of Naval Research.

It is planned eventually to find support to restudy each student four times following his graduation from high school—after 1 year, 5 years, 10, and 20—to find out to what extent he has developed his talents.

## For Health

Plans to provide free health services to Newfoundland's children have been put into operation in the Province. Inpatient hospital care at ward level, which includes diagnostic services and medicines, and outpatient diagnostic care are provided under a program financed jointly by the Provincial and Federal Governments, as in other Provinces participating in Canada's hospital service program. In addition, the Newfoundland government administers and finances a free medical and surgical care program for all children under 16 admitted to a hospital; it is the only Province in Canada with such a program. About 175,000 children, or one-third of the Province's population, are estimated to be eligible for the service.

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The Public Health Service, Department of Health, Education, and Welfare, has begun publication of a monthly report, *Radiological Health Data*, which presents data on environmental radiation levels, compiled from various sources within the Department and from the Atomic Energy Commission and the Departments of Defense, Commerce, and Agriculture. The first issue (April 1960) contains information about surveillance programs in regard to milk, water, and air, and data from selected locations. Starting with the report for July 1960, every third report will contain interpretive statements as well as data. (Price $3 for a 6 months' subscription, 50 cents for single copies, from the Office of Technical Services, U.S. Department of Commerce, Washington 25, D.C.

. . .

Clinical treatment of children with birth defects, research concerning such defects, and training of physicians in dealing with them are being carried on at a study center recently opened at Children's Hospital in Columbus, Ohio. The center is supported by the National Foundation.

## White House Conference

"These Are Our Children," the large exhibition of photographs shown at Washington at the Golden Anniversary White House Conference on Children and Youth (see CHILDREN, May–June 1960, pp. 100–101), is now touring the country. By the end of June it had already been displayed in four cities: Chicago, Rochester, N.Y., Atlantic City, and New York.

The exhibition consists of approximately 350 photographs, mounted in 12 sections, plus an entrance arch. Among the titles of the sections are: "For every child—protection and care, security and love"; "Childhood is a time for discovery and great adventure"; "The handicapped find help and confidence"; "This is young America—our strength, our future, our pride."

Inquiries regarding the exhibition and its future availability should be directed to Mrs. Margaret K. Taylor, 1960 White House Conference on Children and Youth, 330 Independence Avenue SW., Washington 25, D.C.

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The White House Conference is currently offering two special "libraries" at the package price of $10 each, plus $1.30 for postage and handling. Library No. 1 consists of: the three volumes of background papers, "The Nation's Children"; the chartbook, "Children in a Changing World"; the résumé of national organizations' reports, "Focus on Children and Youth"; the summary of States' reports, "The States Report on Children and Youth"; and the "Conference Proceedings," to be published later this year. Library No. 2 includes: "Children in a Changing World"; "Focus on Children and Youth"; "The States Report on Children and Youth"; "Reference Papers on Children and Youth"; the survey papers, "Children and Youth in the 1960's"; and the "Conference Proceedings."

Order directly from the Publications Division, White House Conference on Children and Youth, 330 Independence Avenue SW., Washington 25, D.C. A list of prices for the individual items may be obtained from the Conference.

The Conference Proceedings will include background descriptive material, condensations of selected papers, and a composite report of the Forum recommendations. A separate volume on the recommendations issued last month is now available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C.; single copies 25 cents; quantities of 100 or more 25 percent less.

The Conference is also distributing six 12-inch double-face recordings of excerpts from 12 of the major speeches and discussions, at $12.75 per set. Each excerpt lasts 20 minutes and can be played on any 33⅓-r.p.m. record player. Speakers included are: President Eisenhower, Secretary of Health, Education, and Welfare Arthur E. Flemming, Marion D. Hanks, Abraham J. Heschel, Reuben Hill, Irene M. Josselyn, Roy E. Larsen, Robert B. Lawson, Lawrence J. McGinley, Liston Pope, Milton G. Rector, Abram L. Sachar.

## Mental Retardation

To prepare workers for serving children with emotional and learning problems, the Devereux Foundation, Devon, Pa., is offering 10- to 12-month traineeships for persons who have at least a 10th-grade education. The trainees are given a course in child development as well as supervised experience in day-to-day care of children and adolescents in a residential therapeutic institution. The age range is open; mature teenagers are eligible for consideration. Trainees receive stipends of $150 a month plus room and board.

. . .

That mentally retarded children do not get as good dental care as other children is suggested in the results of examinations recently conducted in four rural Minnesota counties by the dental health section of the State department of health. The examinations were made as part of a 4-year study of the mentally retarded begun in 1957 with funds made available by the Children's Bureau. (See CHILDREN, September–October 1958, p. 197, and January–February 1960, p. 36.) Dental examinations were given to 113 mentally retarded children not in institutions. Their average age

was 9.4 years; their average IQ, 57.

The study showed that 37 percent of the 113 mentally retarded children had never been examined by a dentist; for other children the percentage was 19. Sixty-six percent of the mentally retarded children had at least a moderate form of periodontal disease. Forty-two percent of the retarded used a toothbrush once a day, 16 percent never. According to other studies among average children more than 90 percent brush their teeth at least once a day, and only 4 percent never brush them. Among the retarded 13 to 17 years of age, only 17 percent of teeth which had had impairments had been filled, as compared to 50 percent in the nonretarded. The retarded had lost a greater percentage of teeth than the other children.

Sixty percent of the retarded children were reported as cooperative or at least impassive, during the dental examination. Twenty-three percent were reported as untreatable except under general anesthesia.

# Guides and Reports

AID TO DEPENDENT CHILDREN; a family service—the community responsibility. National Social Welfare Assembly, 345 East 46th Street, New York 17. 1960. 36 pp. 50 cents; 40 cents in quantities of 25 or more.

A guide for citizens' groups which describes the purpose, philosophy, and administration of the Federal-State ADC program, the characteristics of families on the ADC rolls, the values of the program to children and society, and the program's problems and limitations, including suggestions for evaluating the program locally. Prepared by the Assembly's ad hoc committee on Aid to Dependent Children.

THE CLEVELAND STORY: community planning spotlights child protection. American Humane Association, 896 Pennsylvania Street, Denver 3, Colo. 1959. 22 pp. 15 cents. Quantity discounts on request.

Two papers reporting on how cooperative action of voluntary and public agencies and interested citizens, lay and professional, resulted in the establishment of a service for neglected children within the public welfare department.

CHILD WELFARE AS A FIELD OF SOCIAL WORK PRACTICE. Statement prepared by the Child Welfare League of America and the Children's Bureau, Social Security Administration, Department of Health, Education, and Welfare. 1959. 32 pp. Code CW-15. 75 cents. Copies for sale by the League, 345 East 46th Street, New York 17.

Describes aspects of social work practice relating to children and youth and identifies the specific characteristics of child welfare work as a field of practice in which social work methods (casework, groupwork, community organization, administration, and research) are used in behalf of children and youth.

INTERPROFESSIONAL TRAINING GOALS FOR TECHNICAL ASSISTANCE PERSONNEL ABROAD: report of an interprofessional conference on training of personnel for overseas service. Irwin T. Sanders. Council on Social Work Education, 345 East 46th Street, New York 17. 1959. 198 pp. $3.

Discusses efforts to bring about social change abroad through programs for agricultural development, social welfare, education, and public health, and training for personnel.

BRIEF ENCOUNTERS IN FAMILY LIVING; ten family life stories with suggestions for meeting everyday problems. Jean Schick Grossman. Play Schools Association, 41 West 57th Street, New York 19, N.Y. 1959. 68 pp. 75 cents.

Based on real situations involving 10 families and planned especially for parents and for persons working with parent groups, each chapter deals with the everyday problems facing parents with small children and offers suggestions for dealing with them.

AN ADOPTED CHILD'S MEMORY BOOK. Marion A. MacLeod. C. R. Gibson & Co., Norwalk, Conn. 1959. 72 pp. $5.

This "memory book," planned by an adoptive mother for keeping records of an adopted child, in the manner of the usual "baby book" includes space for snapshots, handprints, and footprints; measurements; medical and health records; and other information about the growing child. The book is accompanied by a pamphlet, "Let's Talk With Adoptive Parents."

THE COUNTY DEPARTMENT OF WELFARE, A SERVICE AGENCY: summary of material presented by all participants in an institute sponsored by the American Public Welfare Association under a grant made by the Rockefeller Brothers' Fund. American Public Welfare Association, 1313 East 60th Street, Chicago 37. 1959. 33 pp. $1.

Discusses the scope of public welfare services and the problem of defining such services, and presents some guide lines for planning and evaluating agency programs.

EIGHTY-SIXTH ANNUAL FORUM OF THE NATIONAL CONFERENCE ON SOCIAL WELFARE, SAN FRANCISCO, MAY 24–29, 1959.

Selected papers from the Forum are included in the following volumes:

THE SOCIAL WELFARE FORUM, 1959; official proceedings. Columbia University Press, New York. 1959. 276 pp. $5.

CASEWORK PAPERS, 1959. Family Service Association of America, 215 Park Avenue South, New York 3. 1959. 143 pp. $2.50.

COMMUNITY ORGANIZATION, 1959. Columbia University Press, New York. 1959. 133 pp. $2.50.

SOCIAL WORK WITH GROUPS, 1959. National Association of Social Workers, 95 Madison Avenue, New York 16. 1959. 160 pp. $2.50.



U.S. GOVERNMENT PRINTING OFFICE: 1960

## SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

**Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.**

HOME PLAY AND PLAY EQUIPMENT FOR YOUNG CHILDREN. Adele Franklin. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No 238. Revised 1959. 1960. 23 pp. 15 cents.

A complete rewriting of an earlier publication, this pamphlet discusses children's needs for play, indoor and outdoor, quiet and active, alone and with other children. Directions are given for building simple outdoor play equipment such as swings and a sandbox.

CHILD CARE ARRANGEMENTS OF FULL-TIME WORKING MOTHERS. Henry C. Lajewski. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 378. 1959. 26 pp. 15 cents.

This report of a survey, made for the Children's Bureau by the Bureau of the Census, shows that 2,873,000 fully employed women in the United States in 1958 had children under 12. About 8 percent of the 5,073,000 children involved were expected to care for themselves while their mothers were at work. The report gives statistical information on the characteristics of fully employed women and the types of child care arrangements made. Breakdowns are given according to the mother's race, geographical area of residence, and type of employment.

HEALTH, EDUCATION, AND WELFARE TRENDS, 1960 edition. Department of Health, Education, and Welfare, Office of Program Analysis, Office of the Secretary. 1960. 90 pp. 50 cents.

This is the first in a series of annual statistical reports to be made available to the general public by the office of the Secretary of Health, Education, and Welfare. It presents data from various units of the Department, other Federal departments and agencies, and a number of national voluntary organizations, showing trends in a wide range of fields affecting health, education, and welfare in the United States. Among the subjects included are: births and deaths; the labor force; Federal grants-in-aid; medical care; manpower in health, education, and welfare; juvenile-court cases. Each page includes a brief textual statement, a graph, a supporting table, and notes referring to sources of the data.

A LOOK AT JUVENILE DELINQUENCY. Lincoln Daniels. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 380. 1960. 50 pp. 25 cents.

Addressed to the general public—especially community leaders—this publication discusses what juvenile delinquency means, the extent of the problem, what causes it, whether it can be prevented, what helps to prevent it, and how delinquents can be rehabilitated.

CHILD WELFARE STATISTICS 1958. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 55. 1959. 42 pp. Single copies available from the Bureau without charge.

Includes statistics on children receiving child welfare services from public or voluntary agencies or both; on child welfare personnel, including salaries, caseloads, and vacancies; on expenditures, including payments for foster care; and on children adopted.

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# children

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SEPTEMBER • OCTOBER 1960

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## Social Work and Law

## Evaluating a Youth Service

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THE FIGHT AGAINST TRACHOMA through the provision of supplies for the examination and treatment of school children such as these children in Taiwan is one of the efforts furthered by UNICEF, the United Nations Children's Fund. Supplementing the funds raised by government and other channels for such activities are funds collected by American children on Halloween under the trick-or-treat program sponsored by the United States Committee for UNICEF. The program will reach its 10th anniversary this October.

With a law degree from the University of Minnesota and a Ph. D. in social work from Bryn Mawr College, Harriet L. Goldberg was in the private practice of law and family counseling in Toledo, Ohio, before coming to the Children's Bureau 3 years ago. Previously she had been social work consultant for the Lucas County, Ohio, Domestic Relations and Juvenile Court; and assistant corporation counsel for the City of New York, assigned to the Children's Court.

One of the initiators of the American Bar Association's family law section, John S. Bradway was its secretary in its first year, 1958–59. He was instrumental that year in organizing a multidisciplinary institute on family law at Duke University, where he was for 28 years professor of law and where he directed a legal aid clinic.

In the 3 years she has been in her present position Ann W. Shyne has been studying the components of change in social casework and participating in a demonstration-study project in public-health nursing for maternity patients, in addition to carrying on the youth bureau study described in her article. Previously, she was for 10 years with the Family Service Association of America. She has a Ph. D. in social economy from Bryn Mawr College.

Goldie Cornelinson, left, a fellow of the American Academy of Pediatrics, is a graduate of the University of Michigan School of Medicine and of Columbia University School of Public Health. Her co-author, Fanny H. Kenyon, right, majored in public health at Ohio State University and received her M.D. from Wayne State University College of Medicine.

Mabel H. Parsons has been with the mental retardation project she describes since 1958, the year she received her master's degree in home economics from the State University of Iowa. Though her home management work with parents has been discontinued for lack of funds, Mrs. Parsons is remaining on the staff of the university's child development clinic to do nutrition assessments of mentally retarded children.

A graduate of the New York School of Social Work, Dorothy Waite had 27 years of experience in various capacities in the division of children and youth of the Wisconsin State Department of Public Welfare when she was made division head last February. Previously she was chief probation officer for the La Crosse County Juvenile Court. She began her career as a caseworker in a family service agency.

## ◀ *the authors*

# SOCIAL WORK AND LAW

HARRIET L. GOLDBERG

*Specialist on Child Welfare Legislation, Division of Social Services, Children's Bureau*

FAMILY LAW has grown rapidly in recent decades. States have tended to supplement or modify common law and earlier statutory law by enacting legislation which delineates rights and responsibilities of parties involved in adoptions, paternity, legitimation, support, neglect, and related subjects. All States now have provisions for reciprocal enforcement of support and for additional welfare services and assistance. A significant contributing element in this growth has been the great expansion in social service programs, both public and voluntary.

Many of these developments are the product of multidisciplinary efforts, especially of social workers and lawyers. They have also led the way in stimulating legal-aid services. Their joint endeavors are exemplified in the work of the Committee on Lawyer-Family Agency Cooperation of the Family Service Association of America.[1]

These substantial improvements in the realms of family law and social service make necessary the highest degree of cooperation between practitioners in two professional groups whose members have a fundamental similarity in purpose and in philosophy. Among social workers and lawyers there is a high regard for the dignity and worth of people and for the rights of individuals. Both professions exist to help people, and they recognize that every case differs in some respects from every other. Thus, they share the concept of individualization and its application in daily practice. But in each, the practitioner needs to know more about the philosophy and practices of the other field in order to serve his clients better.

While it is not necessary that social workers be students of jurisprudence to carry out their functions, an understanding of the basic elements of court process, especially the fundamental safeguards guaranteed by our Federal and State constitutions, would greatly facilitate communication with lawyers, particularly in family litigation where the social study is recognized as invaluable.

In our system of government, courts exist primarily to protect rights and to enforce legal responsibilities. Our adjudication process is a precious heritage, the result of valiant struggles for human liberties. This heritage is a cluster of rights such as the right not to be called to court without notice of the matter to be litigated; the right to be notified with time to prepare when one's interests are to be litigated; and the right to a fair hearing. These are rights that attorneys protect.

Briefly, a fair hearing means (1) the right to be represented by a lawyer, (2) an opportunity to be heard, (3) freedom from secret proceedings, (4) the right to know what data are used by the judge as a basis for his findings concerning the allegations of the petition or complaint, and (5) orderly proceedings. Another essential to justice is a judicial record for review purposes.

Our adjudication process has been tested and refined throughout centuries of juridical experience. In adjudication, the right of due process with its requisite ingredients of notice and a fair hearing becomes a reality. If either of these essential ingredients is missing, the adjudication is a travesty upon justice.

Vexing questions arise regarding the confidential nature of information contained in reports of social studies. Many social workers are troubled about the need for disclosing such information in court proceedings. Trial lawyers and other lawyers say that if these reports are to be used by the judge as a basis for his findings concerning allegations in the petition then the data should be offered in evidence and the worker should be available for direct examination and cross-examination. The point was stressed recently at a joint meeting of lawyers and social workers in Akron, Ohio: "Social workers should have enough conviction about their opinions as expressed in their summaries to court, to be willing to appear for cross-examination . . ."[2]

Relationships between lawyers and social workers sometimes become strained when a social worker attempts to advise on the legal phases of adoption, guardianship, and commitment and release of mentally retarded and mentally ill persons or to construe statutes without knowledge or understanding

of applicable legal concepts and principles. Sometimes this is due to a lack of awareness of the legal elements present or to a belief that clientele cannot afford legal services. But nonlawyers are just as unqualified to render legal service as lawyers are to engage in social work—and when lawyers perform social service functions, such as placing babies for adoption, similar strain results. Today, when increasingly social agency caseloads cut across all economic levels, many of their clients can well afford moderate legal fees. And for those who cannot pay, legal aid services are often available—or should be available—either in a legal aid bureau or within the membership of local bar associations.

### *Social Studies and Reports*

In modern social legislation, the social study and the social report are regarded as indispensable components in judicial proceedings involving termination of the parent-child relationship, adoption, custody, neglect, and delinquency. And so has come an extension of legislative mandates for such studies and reports in adjudications. Because the most important aspects of these studies involve interpersonal relationships of family members, social caseworkers are particularly well equipped to make them.

The social-study process, like the judicial process, has evolved from the experience of many people and has been tested and refined through many years of use. It, too, can be analyzed and taught. Just as it would be well for social workers to understand the major components of the judicial process, so too it would be beneficial for lawyers to understand the major elements of the social study.

Whatever the subject of the social study—child custody, termination of the parent-child relationship, adoption, neglect, or other—the process is a social one. Generally speaking, the social worker should not be placed in the role of proving or disproving allegations contained in judicial pleadings; the social study should be related primarily to disposition of the case.

The social worker brings to the social study a body of professional knowledge of human motivations and behavior and the physical, social, and economic circumstances that influence the life patterns of individuals, plus knowledge of constructive helping methods. His skillful application of this special knowledge enables him to make an accurate assessment of the social situation presented. Out of this assessment is evolved a proposed plan geared to the immediate and long-range needs of the child and his family. For example, the plan may be to continue social casework services for family members while the child remains in his own home or in foster care. Or the plan may be adoption. Involvement of the family in planning and decision making is a cardinal principle of social casework.

At the outset of each social study in connection with court proceedings, the worker should explain to the persons concerned the purpose of the study and the fact that information obtained may be brought out at the judicial hearing. Practice has shown that the worker's frankness does not "dry up" sources of information or affect either the quantity or quality of material he receives. Revealing information long withheld from a spouse is often a relief to the person involved, and may help him to share it with his spouse.

Many delicate questions of confidentiality are posed by judicial proceedings. Relatives and others who give information about cruelty to children, parental unfitness, or personality abnormalities, or information that would tend to make defendants poor probation risks often do not want their identity revealed. Yet the source of the data may have an important bearing on its probative value. Sometimes one spouse discloses to the worker previous criminality or delinquency, previous marriages, or extramarital connections that are unknown to the other spouse.

If the worker discloses the information, family relations may suffer. If he withholds information which is pertinent to the litigation, he may endanger children. Perhaps this requires a balancing of risks. If parental fitness is an issue, as in neglect, custody, and adoption, then the data should not be withheld, since the child's welfare is paramount. For example, when a couple has petitioned to adopt a child, they are offering themselves as suitable adoptive parents. If during the social study one spouse gives the worker information as just described, this should be made known to the court because it directly concerns the question of whether the adoption decree should be granted or denied in the child's best interests. If during the discussion with the spouse the worker makes clear his responsibility to reveal such information, the adoption petition might be withdrawn, which would be preferable to a disclosure in court.

In discussing social records we should distinguish between two kinds of litigation—(1) litigation in which the social study is made at the court's request or because the agency is a party to it and (2) litiga-

tion, such as personal injury suits, which is not related to the social service that has been given to the parties involved. In the first type, social data are given to the court in furtherance of the judicial action, but even here, it is a social report, not the case record, that is presented to the court. In the second type, usually information from the file need be disclosed only at the social agency's discretion unless it is subpoenaed. Statutory protections should be provided for social agency records in the interests of the individuals concerned and of the community. To achieve this, social workers need the help of attorneys.

The concept of selectivity operates both in recording for the case record and in preparing the social report for the court. The more skillful the worker, the more selective he will be. He will confine his recording for the case record and also for the report to the salient, the significant, and the relevant. But his task is a complex one, since the implications of specific information may not be apparent until near the end of the study. At times only an accumulation of data and the worker's continuity of experience with the clients reveal a meaningful pattern.

As would be expected, the social case record contains much material that does not pertain to the court action in which the study was made. This is especially true of treatment aspects and in process recording. Of necessity, the record reflects the scope and depth of the study, and these vary in accordance with the case situation. Statutory provisions for social studies do not require that the entire social service record be brought to court. The report to the court is a selective distillation of the social case record, prepared in relation to the specific judicial proceedings.

Diversity of opinion exists as to whether the worker's recommendations should be included in the social report. Some lawyers and judges welcome these. Others feel that the inclusion of recommendations impinges upon the judicial function. These opposing viewpoints are illustrated in the adoption legislation of two Eastern States. In one, there is a statutory provision that the report is to contain recommendations.[3] In the other, these are expressly prohibited.[4] Actually, the worker's recommendations can be exceedingly helpful to the court. Actually, making recommendations does not infringe upon the judicial function. The power to decide is distinct from the power to recommend.

How should the social report be used in the court proceeding? Here it is well to differentiate between data that are used as a basis for the judge's finding regarding allegations in petition—as in some adoption cases—and those that are used by the judge afterward in disposing of the case.[5]

Only if social data on the litigated issue is offered in evidence for the judicial record, and the worker is present for direct- and cross-examination can counsel for both sides have an opportunity to test, to explain, and to rebut material. The court record, which is imperative for both trial and appellate uses, will then show this process.

More latitude is allowed in regard to judicial disposition of the court case. Thus, social data that might not be admissible in evidence to establish allegations in the petition can be considered by the judge in disposing of the case.[5] Here, the trained social worker's opinions are of utmost value.

Some judicial decisions take cognizance of the social worker as an expert witness. As has been pointed out in the *University of Chicago Law Review*, "Courts recognize social workers as experts in family relations."[5] Rules of evidence regarding hearsay are sometimes relaxed to allow the use of social data when the social worker is present as a witness.

### *Judge Helped by Social Data*

If the judge finds that a child is neglected, then he must decide what should be done to protect the child from further neglect. Should the child remain in his home under the protective supervision of a social agency? Or should he be placed in foster care with a change of custody or the appointment of a guardian? Or is the neglect so grave and the prospects for improvement with limitations upon parental rights so bleak that parental ties should be completely severed to free the child for adoption? Social data may well provide the soundest answer.

At times, judicial decrees are contrary to the worker's recommendations. Nevertheless, responsibility for judicial decisions rests with the judge, and there are many factors which he must weigh and balance in arriving at them. If the workers who have made the recommendations are court employees, frank discussion with the judge may aid in mutuality of understanding. If they are not court employees, they might consider the advisability of appellate review. A number of important questions in family law, especially those of a highly controversial nature, remain blurred for lack of appellate review of lower court decisions.

Social workers and lawyers can join forces in

many constructive ways. One that is gaining increased momentum is the development of legislative proposals in various areas of family law. Often, social workers are the first to see in their everyday practice the desirability of legislative change. The combined efforts of social workers and lawyers are helpful in developing standard or model legislation and also in preparing individual legislative proposals.

Two steps are involved in this process: First, a careful study of the problem and its extent; then an analysis of what is needed to cope with the problem. A crucial question is: Can existing law be adapted to present social conditions either by changes in administrative regulations and procedures, by modifications of attorney generals' opinions, or by more recent judicial decisions?

If it is ascertained that new legislation is essential, the question arises as to whether the legislative change should be by amendment of present statutes or whether it would be more desirable to advocate new statutes. Sometimes, even when new statutes would be more desirable, it is found advisable to propose amendments in order to obtain any action or to avoid jeopardizing gains which have already been achieved.

Social workers are in a favorable position to correlate data on the extent of the need and to offer concrete suggestions for meeting the need. Lawyers are needed to study these suggestions in connection with related law, both substantive and procedural. In one State after new adoption legislation was enacted, it became apparent that changes would have to be made in the child placement law if the new legislation were to accomplish its purpose. In another State a legislative commission found that proposals for changes in the State's juvenile court laws would be futile unless statutory changes were made regarding responsibilities of local public welfare authorities. The earlier the lawyers are brought into discussions to help devise a sound social policy, the more likely it is that this will be translated into workable legislative language.

It is axiomatic to lawyers and judges that no statute stands by itself. It has to be skillfully studied in conjunction with the body of related substantive and procedural law—statutory and case law which includes major judicial decisions applying and interpreting statutory provisions. Here are situations where social workers, no matter how familiar they are with agency operations under a specific statute, need the help of lawyers who are equipped to make the requisite interpretations.

The Family Law Section of the American Bar Association, the Commissioners on Uniform State Laws, the Council of State Governments, State legislative councils and research bureaus provide channels through which social workers and lawyers can work together in the development of legislative proposals.

When lawyers are consultants or staff members of social agencies, there are a variety of ways in which their services are advantageous to programs. One consists in assisting the agency with legal phases of organization. For instance, when social workers inform agency lawyers of the evolutionary character of social service, the lawyers will draft agency constitutions and bylaws so that purpose is expressed broadly. This will protect the agency from being precluded in the future from serving the people most in need of their services, as some children's institutions have been because of outmoded restrictions in their charters.

Legal thinking can be a potent help in the exercise of administrative discretion.[6] Every social agency has a broad area of discretion. At times, it is found that the agency's area of discretion has been unduly circumscribed by an unawareness or misunderstanding of legal authorizations. For example, the staff of one agency erroneously believed that applicants for care had to meet a requirement for legal settlement in the locality when in fact the law governing the agency authorized care to all in need who resided in the State.

Legal training in the analysis of problems gives the lawyer a special usefulness in helping agencies develop policies and procedures. This is particularly applicable in public agencies with a statutory foundation. Lawyer staff members have an obligation to implement within the confines of the law rather than to focus solely upon what cannot be done.

Another area in which social workers and lawyers can function together productively is in developing guide materials for subject areas in social service. For example, "Standards for Specialized Courts Dealing with Children," developed with the aid of such an interprofessional committee, has proved useful to legislatures, legislative commissions and committees, courts, workers in public and voluntary agencies, and students of both social work and law.[7]

Staff development in public and voluntary agencies is enriched through social-legal contributions at all staff levels—practitioners, supervisors, and administrators—and in all types of service—public

assistance, institutional licensing, marital counseling, services to children in their own homes, foster care, adoption, services to unmarried parents, services to the mentally retarded and the mentally ill, and others. The fusion of interest in social and legal protections offers both professional groups opportunities for continued growth and equips them to render a higher quality of service.

The social worker needs legal advisory assistance in preparing cases for judicial action. Timely collaboration between social worker and lawyer will prevent many disappointments with court decisions. Moreover, legal advice will also obviate the necessity for court action in certain cases in which out-of-court settlements, adjustments, and arrangements for compliance can be made. The lawyers on an agency's staff or board can also do much to strengthen agency relations with bar associations and courts in the community and in the State.

Currently there is a wholesome trend toward the employment of attorneys in social agencies. This often results in more productive cooperative efforts than when lawyers who serve an agency are members of State attorney generals' staffs, of county attorneys' offices, or even of the agency's board. When social workers and lawyers are colleagues there is greater opportunity for continuity in their relationships and a resultant heightened understanding and productivity. To avoid possible conflicts of interests, lawyers who are agency-staff or board members should represent the agency, not the agency's client, in any matter pertaining to the agency's program.

Social workers and lawyers have much to gain by inclusion in their professional training of mutual curricula content. It is the rare law school which includes social work material in its courses. But just as it is becoming increasingly clear that forensic medicine should have its place in the law school curriculum, so too, it may one day be recognized that the legal phases of social work should have a place in the lawyer's training. Perhaps this can be achieved through an extension of the legal-aid programs which some law schools provide for seniors and through an expansion of family law courses.

Recently the Ford Foundation granted $800,000 to the National Legal Aid and Defender Association for a 7-year program to develop legal-aid clinics and internship programs at 12 law schools. The purpose is "to give direct educational experience in the public and social aspects of law and the lawyer's role in society."[8] Cooperating in this undertaking are the American Bar Association and the Association of American Law Schools. This is a hopeful note as is the increased interest of family law teachers in social-legal guide materials.

From the start of social-work education its leaders recognized the desirability of including material on law in the professional curriculum. However, some students graduate from schools of social work with little knowledge or understanding of the interrelatedness of law and social-service practice. Such a lack is a serious handicap in their work, for there are legal involvements in virtually every social-work caseload.

Today, practically all schools of social work are affiliated with colleges or universities. They therefore have easier access to law faculty members than ever before. Interdepartmental arrangements for faculty exchanges would facilitate the growth of family law and at the same time enrich both law curricula and social-work curricula. Persons selected to teach the legal aspects of social work should be familiar not only with jurisprudence but also with social work theory and practice. With the increase of specialized courts containing social-service staff of high caliber, internship programs could be inaugurated for law students and social-work students.

### *Conclusion*

The solution to present difficulties in relationships between lawyers and social workers lies not in one profession's attempting to substitute its efforts for that of another but rather in a mutual awareness of and respect for areas of professional competency and in working together for the development of services. Only in this way will people be well served. Social workers and lawyers have such a community of interests and the need for their combined services is so great that they have a deep obligation to be partners, especially in the realm of family litigation.

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# A SUGGESTION FOR IMPROVING FAMILY LAW

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SUGGESTIONS with respect to improving family law comprehensively may come to us from at least three sources: the lay public; members of one or other of the professions interested in the family; and some type of interprofessional group.

To the man in the street, the term family law may bring up vivid memories or ideas of a place where domestic difficulties are dealt with specifically and, depending upon the outcome, either solved, prevented, or perhaps aggravated—a law office, a building full of mysterious judicial machinery, a jail, a courtroom. Or it may bring a picture of groups of officials or quasi-officials—judges, lawyers, court clerks, probation officers—who treat him as though he were a contestant whose only thought was "to win." If asked for suggestions for improving family law, laymen may make proposals based on their personal, and perhaps highly emotional, reaction to social, economic, or religious pressures; and there will be no unanimity among them.

Minds trained in the law or in other professions concerned with the well-being of the family are better equipped to see the importance of many aspects of the subject which may seem obscure, or perhaps irrelevant, to the layman. But if we gather representatives of all the professions together and ask them their opinions on where family law needs improvement, since each has its own point of departure, we may end with a group of irreconcilable recommendations reflecting an essential difference in viewpoint between the legal and nonlegal professions.

The nonlegal professions generally view with reserve, if not alarm, the use of force in efforts to solve the problems of their clients or patients. They are apt to regard the members of the family not as adversaries clashing over their "rights" but as ailing people who need not the controversy of legal battles, but treatment conducive to healing. Since their approach is therapeutic, their first suggestion for improving family law might be to reduce its scope, making it applicable only to those problems which the other professions have tried unsuccessfully to solve. This might not arouse support from lawyers.

If, on the other hand, we try to see our topic through the eyes of any single profession, the question is "which profession?" The legal profession, while a logical choice, has its unique perspective.

When the lawyer looks at the field of family law he sees a mass of rules, familiar to him but more or less bewildering to all those who have not passed through his particular discipline. These rules are created and promulgated by legislatures and courts. Behind them he sees here and there various pressure groups whose members have been successful in securing the passage of legislation or who may perhaps have even financed the litigation of test cases for the purpose of securing an opinion of a court of last resort.

Thus the lawyer, while not the only professional with a contribution to make, is in a strategic position to render aid in improving any field of the law. But improving the law is only one of the services expected of him. He is also expected to predict dependably. Clients ask him to tell them what their legal status will be if they pursue certain proposed courses of conduct. If the law is relatively stable the lawyer, on such an occasion, can and does give a good account of himself. But if it is constantly in flux, prediction becomes a difficult and even a hazardous professional undertaking. So on proposals to improve comprehensively the field of family law we may expect the lawyer to be somewhat ambivalent.

If the problem of family law being considered is one peculiarly within the proper jurisdiction of any one profession, certainly suggestions which that profession may have toward improvement deserve the most careful consideration. But when we do make

use of material from any professional source we should act with a full understanding of the limits of its professional jurisdiction, as well as of its undoubted values. Each profession has a central core of experience, knowledge, and skill where its exclusive competence is recognized. From that core its competence extends, perhaps not to a specific perimeter, but, somewhat like the atmosphere of the earth, getting constantly thinner.

To achieve a really satisfactory solution to the more complex problems of family law all of its aspects must be dealt with expertly so that when each client walks away from his personal contact with it he may be in better shape, in every possible respect, than he was when he first came for help, or—to use the legal phrase—for justice. If we could tell in advance accurately whether the particular problem could be answered completely by the resources of any particular professional field or fields, efforts to improve expert services to the community might easily be limited to establishing bridges between the professions. But too often we lack this comprehensive diagnostic power. Moreover, if we oversimplify our concept of a bridge we may not give proper consideration to two factors: interprofessional duplication of effort with no surveyor to run a connective boundary line, and interstitial areas where no professional service at all is available. Until we are sure we have the whole field of the family in focus we are unable to say where improvements in the field of family law should begin or end.

Thus, it seems, we confront the discouraging possibility of little or even no improvement in family law. This would be true if there were not the possibility of a further step—the creation of a group of "interprofessionalists" who could approach the subject of improvement from a more comprehensive angle and, possibly, make those long-range, far-reaching decisions, visualize those ultimate goals, and set in motion those objective remedial processes which are prerequisites to improvement on more than a "happenstance" basis.

The reader is apt to visualize an "interprofessionalist" as a member of a committee of people, each trained professionally in his own field, brought together under one roof to contribute something from his specialty to a reservoir of ideas on a particular subject. The product of such a group is usually something of a composite, reached, in all probability, by a compromise. But the interprofessionalist like the internationalist in world affairs would be a disinterested evaluator—a person trained to see across the professions. This would be a new sort of discipline—one in which the goal is to teach the student to think basically along professional lines rather than in a specialized way within separate professional areas.

The phrase "basic professional thinking" assumes that lay people think on one level and professional people on another. It seems reasonable to assume that under those special differences which proclaim the lawyer, the doctor, and the clergyman, there are basic similarities in approaching problems which distinguish all three from the layman. If the elements of this basic approach could be taught to a group of competent students with some generalized knowledge about the services each profession offers, there might be developed some thinkers who could consider the whole subject of family law without a specialist's bias.

If the best thinking from each interested profession would flow to such a group of nonspecialized but trained individuals, the group might be in a position to fit the innumerable pieces of the gigantic jigsaw puzzle of family law together in an orderly if somewhat novel pattern. Free of the fears and attachments of the specialists, they might devise broad programs, inclusive concepts, far-reaching predictions, which could then be crystallized into specific proposals for legislative action.

In order to get such a group started, the public would have to be convinced of the need of it rather than of another advisory committee of visiting experts in specialized fields.

Consider some of the limitations that can impede the progress of a group of dedicated professionalists. The group may consist of a lawyer, a psychiatrist, a psychologist, a social worker, a marriage counselor, and a probation officer, or a similar group of people—all distinguished in their fields. No sooner do they start talking than up bobs the by no means inconsiderable problem of communication across professional frontiers. The chances are that: (1) each person has grown accustomed to a set of linguistic shortcuts used within his own profession but which mean little to anyone else; (2) each person has different connotations of a number of familiar words. As a result valuable time is spent at the outset in developing a common vocabulary. Perhaps disagreements arise and the members of the group lose their rapport.

Next comes the danger of wrecking the enterprise on the rocks of professional protocol. Where each person is the top man in his own field there may arise

the problem of which profession shall preside. The analogy to the experience of international conferences is not too farfetched.

A third difficulty has to do with determining the comparative effectiveness of the resources in which the various professions operate. Each member of the group finds it easy to speak affirmatively of those procedures in his field which are widely accepted, but finds it difficult to criticize anything his profession does which may not be very effective. This may put the committee's total perspective out of focus.

Once a man has been trained in the traditions of one profession it is difficult for him to pass upon the value of information coming from other fields of equal dignity in which he is largely or even completely a stranger. For example, a lawyer may be actually shocked when he finds that some members of other professions regard the "adversary process" in litigation of family problems as undesirable because it brings force into the effort to solve such problems.

Presently those of us who are interested in improving family law tend to make two assumptions, both of which may be rebuttable. One of them is that the layman is able to "diagnose" his own family problem and determine with some degree of certainty in which professional field he may expect to find a satisfactory solution. The second assumption is that once a person has selected the field he wishes to consult he is able on his own account to evaluate the various practitioners in that field and knock at the door of the one who will do the best work.

A receptionist and screening bureau somewhat on the basis of the machinery presently in operation at a lawyer's reference service, but staffed by interprofessionalist "diagnosticians," would be an improvement. The benefits to the community of such an objective screening agency in saving time and accuracy of "treatment" or solution would be immense. To the lawyer who protests that this device might keep clients from coming to his office to learn their legal rights and that consequently they might lose some or all of those rights, the ready answer is that, by the same token, his group of clients might well be substantially increased. That all family problems should be examined from the point of view of whether a lawyer could help in their solution is no more than common sense. But they should also be examined from the standpoint of their needs for other professional services.

Lawyers and perhaps members of other professions may presently be in a frame of mind to consider a plan to develop interprofessionalists. For many years individual lawyers have been conscious of the need to make use of nonlegal community resources in dealing with some of the family problems which have come to their attention. Lawyers have been in the forefront of pressure groups promoting improved adoption laws, child and adult probation, custody plans and other similar matters, and the provision of services in juvenile and family courts. But these contributions have been at best occasional and made through committees whose results have been achieved through compromise.

Several State and local bar associations have recently appointed committees on family law or on aspects of family law. Many of these committees have found it possible to work cooperatively with representatives of other professions which are interested in the problems of the family. But funds are lacking for continuing such study.

In 1958 the American Bar Association created its Family Law Section and thus gave national scope to the interest of the legal profession in this subject. But its creation alone cannot bring about all the improvement needed in family law. The field involves certain problems which lawyers alone can solve. It also involves problems which will yield to the cooperative pressure of representatives from two or more professional fields working together. But in addition there are problems of such far-reaching importance that their solution seems to call for the objectivity and vision of a specially trained interprofessionalist.

Civilization today is marked by a sharp tendency toward specialization. Recognizing the value—even the necessity—of this tendency does not obscure the danger which might arise if someday we should find that we have gone so far in specialization that nobody can view the picture with perspective. In that day we shall be like passengers in a driverless car, each paying attention to one thing—the gas, the oil, the windshield, the brakes, the wheels, or the springs, but no one attending to where we are going. Someone is needed who can steer.

# FORMER CLIENTS EVALUATE A YOUTH SERVICE PROGRAM

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THE INTRICACY and difficulty of research "assessing the effectiveness of efforts to bring about social and emotional change in individuals" have been pointed out in an article in CHILDREN [1] and elaborated upon in a separate Children's Bureau publication.[2] Increasingly such evaluative efforts have extended beyond assessment by a professionally qualified person of changes observed during the period of service to followup of former clients to determine whether gains have been sustained and to learn their opinion about the benefits derived. CHILDREN has recently reported on one such effort that has taken place in the Netherlands.[3]

The present article concerns the opinions expressed by a group of young adults about their experience as recipients of casework service in New York City during late adolescence. The material was gathered as part of a "short-term evaluation," to use Elizabeth Herzog's terminology, of the youth bureau of the Community Service Society. The evaluation was undertaken by the society's institute of welfare research, which has had considerable experience with followup studies.[4, 5] Part of an administrative review of the youth bureau, the study concerned the characteristics of the bureau's clientele and the range and the outcomes of its services.

The Community Service Society is a multifunction health and welfare agency. Its youth bureau offers casework service to emotionally disturbed adolescents, aged 16 through 20, who are already separated from or need to live apart from their families. Some of the clients live in the community while they receive casework service. Others live in the small treatment residences operated by the bureau, one for boys and one for girls, but are expected to work or attend school in the community. Treatment responsibility for the young people in residence is shared by the residences' professionally trained staff and the caseworker in the agency office.

The bureau receives several hundred applications a year, usually in the form of referrals from other social agencies for admission to the residences. Many applicants are not accepted because the program does not fit their needs or desires, and many more are rejected because the applicants appear to be too disturbed to carry a work or school program while living in the rather unrestricted setting of the houses. Applicants who would seem to be amenable to casework service, but who do not appear to need, want, or be able to profit from the kind of group living experience the houses provide, are offered casework service without residence placement.

A review of the bureau program undertaken in 1957 included study of 74 residence clients and 41 nonresidence clients, each of whom had been interviewed in person by a caseworker at least 5 times. When they came to the bureau these young people were, on the average, 17 years old. Most of them had been separated from their parents for several years. They had had little material or emotional security and were beset by economic, social, and psychological problems. Their level of functioning rarely met community standards. Character disorder was the predominant personality pattern. Neurotic symptoms were also evident though somewhat less common.

The residence clients had, typically, maintained contact with the caseworker for about 8 months and had received, on the average, 16 interviews each. The nonresidence clients had been known to the bureau for about 2 years, receiving, on an average, 72 casework interviews, and had lived for about a year in one of the residences.

Data were obtained on these 115 clients through review of the case records and direct followup of the clients. The method of study has been described in some detail elsewhere.[6] A followup interview was sought with as many of the study group as could

be reached. Questionnaires were mailed to some of the former clients who were not accessible for interviews, usually because they were in military service outside the continental United States.

The followup interviews were held by a caseworker who was not acquainted with the case records and had only minimal identifying data on the interviewees. Each interview focused on the former client's experiences since the termination of service and his recollections of his contact with the youth bureau. The information elicited was reported on a fairly detailed schedule, supplemented by a narrative account of the discussion and the interviewer's observations.

### *Former Client as Informant*

One of the liabilities of using former clients as informants in this study was their unavailability. Unattached adolescents are highly mobile, with few roots through which they can be traced. The followup interviewer, through ingenuity and persistence, secured interviews with 70 of the 115 clients selected for followup, and received completed questionnaires from 12 others, leaving 33 from whom little or no information was secured. However, information from the case records indicates that those who were reached were reasonably representative of the entire group.

Professional help, such as casework service, is but a small aspect of the total life experience of an individual. From 18 months to 5 years had elapsed since these young people had had their last contact with the youth bureau. Marriage and parenthood, military service, and other crucial events occurring in the interval doubtless affected not only their current functioning, but also their perception of youth bureau service and its effects.

Are young adults willing to discuss professional service received during adolescence? The participation of former clients was enlisted through assuring them that they could contribute to improving the service.

A majority of the persons interviewed responded with enthusiasm. They were pleased at the bureau's continuing interest and gratified to find that their opinions were valued. Many were eager to talk about the help they had received, and some were eager to voice their dissatisfactions. On the other hand, a number resisted being interviewed, yielding only after strong persuasion. In most instances the initial resistance evaporated in the course of the interview. By the close of the discussion about 80 percent of those interviewed seemed to the interviewer to have a positive attitude toward participation.

Willingness to be interviewed does not necessarily mean free and frank communication. Many of the young people were rather inarticulate and met the interviewer's questions and comments only with monosyllabic responses. Others talked volubly but on topics more or less of their own choosing. However, the majority seemed to the interviewer to be frank and open. The case readers who knew the clients' backgrounds from the case records usually agreed with the interviewer's impression of an individual's degree of frankness.

Even if the individual is available, interested, and verbal, a single interview is unlikely to give a complete and accurate picture of his level of functioning. However, it is our impression that we obtained a fairly clear notion of what the service received during adolescence meant to the young people reached at followup.

### *Reason for Contact*

Most of the young people interviewed recalled, correctly, that they had come to the youth bureau at the suggestion of or under pressure from another agency; but a few of the residence group who had actually been referred by an agency reported that they had come to the bureau on their own initiative.

At the time of application to the bureau, both referral agent and applicant had been aware of a multiplicity of problems pressing for solution. Need for different housing arrangements, difficulties in family relations, economic need, and employment problems were pervasive from the points of view both of applicants and the persons who had referred them. However, applicants who received nonresidence service were less often aware of problems in family relations than were the referring agents. Less common in the minds of either applicant or referral agent as factors precipitating requests for youth bureau service had been difficulties in relations with peers and with authority figures outside the family, school problems, and problems of physical health.

The one kind of problem on which marked difference was noted in the perception of referrer and applicant at the time of application was that of emotional health or personality adjustment. This was cited by the referring agent in over half the referrals but appeared to be recognized by only a fourth of the applicants themselves.

When asked at followup about the problems that had brought the interviewees to the youth bureau, both residence and nonresidence clients most frequently mentioned housing and family relationships. However, problems in the area of emotional health were cited by half the interviewees, in contrast with the small proportion who had been aware of such problems at the time of application.

The number mentioning problems of emotional health as having contributed to their coming to the bureau equaled the number who recalled economic factors and exceeded the number noting employment as an initial concern. They made such remarks as: "I just had so many feelings and they were so mixed up." "I had like a complex. I just couldn't understand myself." "I was just so depressed." "I had the whole world on my mind." "I wasn't sure I wasn't crazy." "I just couldn't concentrate."

The fact that there was greater recognition of emotional difficulties at time of followup than at time of application might be attributed to at least two factors. Some of these young people undoubtedly were helped by casework service and the process of maturation to achieve a greater awareness of the role of their own feelings and attitudes in their problems during adolescence. Others seem to have been aware, even at time of application, of great psychological discomfort, but to have expressed their difficulties and sought help in terms of the immediate practical necessities of housing, money, and jobs.

### *Assessment of Benefit*

During the followup interview, after general discussion about the young person's experience with the youth bureau—why he came, what he liked and did not like, what he thought he had gained from the service if anything—each interviewee was asked to indicate which of the following phrases best described the effect of the contact on him:

1. Could not have got along without the help received.
2. Was considerably helped.
3. Was slightly helped.
4. Was neither helped nor harmed.
5. Would have been better off without the contact.

The same questions were included in the mailed questionnaire. The case readers were also asked to assess the effect of the service on the client in these terms—on the basis of the case records only, without reference to the followup material—and to predict how the client at the time of followup would evaluate the effect of the service.

Of the 82 interviewees and questionnaire respondents, 15 stated that they could not have got along without the service of the youth bureau. Twenty-nine reported considerable help; 24, slight help; 13, neither help nor harm; 1, that she would have been better off without the service. Thus, slightly more than half the respondents attributed appreciable benefit to the service, and only a sixth felt they had received no benefit whatever from it. Maintenance in the residences along with casework service did not elicit appreciably more favorable evaluations than did casework alone. The residence and nonresidence groups differed only very slightly in their assessments.

How does this assessment by former clients compare with the case readers' estimate of effect? The case readers were much more conservative in their evaluations than the young people themselves. The readers regarded less than one-fourth of the study group as having been considerably helped or unable to have got along without the service, half as slightly helped, and most of the remainder as neither helped nor harmed. They thought that two of the nonresidence clients would have been better off without the youth bureau contact.

The case readers predicted that the former clients—especially those in the nonresidence group—would attribute somewhat greater benefit to the service than they, the readers, believed had actually been derived. However, they did not anticipate the degree of enthusiasm about the effect of service that was shown at followup. They predicted that 30 percent of the former clients would report that they were considerably helped or could not have got along without the service; 54 percent of the followup group so reported. They predicted that 22 percent of the clients would not regard themselves as having benefited; but only 17 percent of the followup group reported no benefit.

When the case reader's prediction and the client's response at followup were compared on a case-by-case basis, the two sets of ratings showed relatively high correlations. (The correlation coefficient is .62 for the nonresidence group and .56 for the residence group. Both correlations are statistically significant beyond the 1 percent level of confidence.) A great many characteristics of client and

service were examined in relation to change in client functioning and to client opinion of effect of service, but very few factors were identified that were as strongly "predictive" of later developments as the case reader's prediction of how the client would assess the service.

The young people varied in their ability to articulate the nature of the gains that they believed had accrued to them from their contact with the youth bureau. However, most of those who considered the experience at all helpful cited at least one type of gain. Many mentioned manifold benefits.

By far the most common gains noted were "better understanding of oneself" and "better understanding of other people." These were cited by over 40 percent of the interviewees. Changes in attitude toward self, toward relatives, toward society were reported by about 20 percent. For instance, one girl said: "I had a weird way of looking at life and this changed completely." A number of the interviewees spoke of increased facility in getting along with other people, particularly with family members and friends of both sexes, and occasionally with authority figures outside the family.

Gains in more practical areas were also cited by the interviewees, but none as often as the intangibles of better understanding of self and others. Facility in finding and holding jobs, ability to manage money matters, ability to carry through school plans, and knowledge of community resources were each mentioned by about 20 percent of the young people. Many of the residence group reported continuing friendships with other young people in the residences. Among a miscellany of other gains were noted: achieving more self-assurance; learning how to be on one's own, "learning how to be a lady," learning to make one's own decisions.

### *Pleasant and Unpleasant Aspects*

Through the followup questionnaires as well as the interviews we tried to elicit the client's recollections of aspects of his experience with the agency that had seemed helpful or pleasant and those that had been unhelpful or unpleasant. The positive impressions reported greatly outnumbered the negative, but the articulate interviewees seemed to express themselves fairly freely about what they had disliked as well as about what they had liked. The old saw that one man's meat is another man's poison certainly applies to this material, for practically every feature described in positive terms by one client was cited in negative terms by another.

Of the young people who had spent a period of time in one of the residences, 60 percent remembered as pleasurable the sense of security derived from living in residence and their relationships with the other young people in the residence. About 46 percent said they had valued their relationships with residence staff. Other favorable comments about residence living had to do with having a room of one's own, the freedom to come and go, having a place to invite one's friends to, the graciousness of the houses, the congeniality of the group in residence, the interest and patience of the staff.

However, an appreciable number of complaints were made about the residences, the most common concerning the house rules, the house staff, and the undesirability of some of the residents. Thus, the same points were cited on both sides of the ledger. Although complaints about house rules were common, some of the former clients objected to the degree of freedom permitted and the failure of staff to set limits when some residents tried to see what they could get away with. One young man said that the house had not taught responsibility because the board charged to working residents was too low to be realistic, while one or two others complained of the amount they had been expected to pay. Many former residents said they had appreciated the interest expressed by the staff, while others had found it intrusive.

Reactions to casework were predominantly positive, but here too responses from different clients were often contradictory. The relationship with the caseworker and the help of the caseworker in thinking out problems were mentioned as assets by well over half the followup group, and the advice of the caseworker received favorable mention from about a third. On the other hand, several of the former clients regarded the personality or attitude of the caseworker or the content of the discussion as a liability. And it was apparent that casework had had little meaning to some of the clients.

The importance to the young person of the caseworker's interest and understanding came through in such comments as:

"With [the caseworker] I could express myself. I could talk with her. She could understand."

"[The caseworker] was the only one who ever understood me."

"She was just like a mother, someone to lean on . . . She taught me how to act, and no one had ever told me."

"He opened my eyes to everything. . . ."

"It was swell for a guy who was suddenly left all alone, thought he knew everything, and found he knew nothing. . . ."

On the other hand, some of the young people had sensed the desire of staff to be helpful but could not take advantage of it. ("There was something in me that kept me from talking.")

The caseworker's approach was sometimes questioned, a few clients wanting a more didactic approach and a few just the opposite. One person commented:

"I wanted to understand what was happening to me in a concrete way, to be given a method to work out my own problems. I was told that the caseworker didn't have a crystal ball and that talking would help. I think she understood my problems but made a mistake in not telling me what to do."

One former client said that the caseworkers were pleasant to talk to but they did not *do* anything. One boy wished he had been given vocational tests. One boy could not tolerate the long silences during casework interviews and was critical of the caseworker for not being more active, for "she's the trained one, she should know how to get you talking about what she wanted to hear."

In contrast, one youth felt that he and his caseworker "didn't blend too well" since the caseworker "had an air of being down to earth, of doing, not just talking" whereas he, the client, was "more intellectual, theoretical." And one young woman ridiculed attempted help in budgeting and vocational planning, when she thought she needed psychotherapy. "Only a child needs a caseworker, someone to encourage him to go to school and be good, but when you're older and you're a troubled person, you need a psychiatrist."

Even the tolerance of the caseworker was irritating to one youth, who said: "They always had a smile. No matter how much you swore at them, you couldn't wipe that smile off." However, this lad conceded that it had been helpful to be able "to get mad and express it instead of letting it pile up inside until it exploded."

Some of the clients saw no point in casework interviews at all. They had come to the youth bureau to apply for residence admission. What was the point of seeing the caseworker? "The worker was nice but I didn't have anything to talk about." "I didn't go to [the residence] to be psychoanalyzed." "Boys House was good except for the casework—that was a waste of time." "Talking about problems doesn't solve them."

What do these diversified reactions to casework add up to? Most of the negative comments were voiced by young people who felt that they had derived little if any help from their contact with the youth bureau and who the case readers also felt had gained little from it. These comments seem to do little more than underline the difficulty of involving in an effective casework relationship the disturbed adolescent of little experience in social relationships and little facility in dealing with ideas, who is torn between massive dependency needs and a drive to make his own way. The extent of favorable perceptions of casework and the caseworker are, on the other hand, heartening, as they suggest that in many instances casework can offer a meaningful and somewhat helpful experience even to adolescents.

Such information about the former clients' level of functioning at followup contributed greatly to the evaluation of effectiveness of service in individual cases. And the reactions to the program expressed at followup have in some instances strengthened and in some modified the impressions of the study staff about particular aspects of the program. However, as has already been mentioned, followup of former clients was but one phase of a study of youth bureau service. The review of case records, only touched on here, was the basis for many of the conclusions of the study staff about the strengths and weaknesses of the program.

The study is in turn but one phase of a broader administrative review. In considering future directions of the Community Service Society's services for youth, the administration is also studying the needs of the community's youth in general and the place of youth services in the Society's total program.

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*How the licensing program of a State health department provides . . .*

# HOSPITAL CONSULTATION TO IMPROVE MATERNITY CARE

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IN MICHIGAN'S population of almost 8 million persons over 200,000 births occur each year, more than 99 percent of them in hospitals. To protect the lives of the new babies and their mothers, as well as of other hospital patients, the Michigan Department of Health gives consultation to over 260 hospitals, licenses the 230 that give maternity care, and evaluates them and about 30 additional hospitals in relation to certification to the State department of social welfare for the care of public assistance recipients. Special consultation service is also given to State mental hospitals and to tuberculosis sanitoria.

Some basic convictions under which the department administers its hospital consultation, licensing, and certification are that:

1. Hospital administrators, staffs, boards, and auxiliaries are as concerned about good patient care and facilities as is the State department of health.

2. It is much more satisfying to both the hospital and the health department when a hospital improves its practices or facilities as a result of good consultation or education rather than as a result of "big stick" action.

3. Hospital consultation calls for teamwork of the highest order on the part of mature individuals who are dedicated to a cause and who have the ability to give consultation, to utilize consultation, and to learn as well as to teach.

4. Leaders among hospital administrators, practicing physicians, and nurses are eager to work with a governmental agency in the development of standards which will be administered by the governmental agency.

## *A Look Back*

Our maternity hospital consultation program began in the late thirties when Alexander Campbell, an obstetrician highly respected by physicians throughout the State and dedicated to the task of bringing about improved maternity care for all women, joined the maternal and child health staff of the department. He was employed under a special Kellogg Foundation grant to give consultation in behalf of obstetric patients in doctors' offices and in hospitals, especially in rural areas, and, in cooperation with the maternal health committee of the Michigan State Medical Society, to stimulate formation of maternal health committees in county medical societies.

When conferring with doctors in hospitals, Dr. Campbell took advantage of opportunities to make recommendations regarding improvement in hospital facilities as well as in patient care. During the next few years the hospital consultation program was strengthened by the employment in the maternal and child health division of a pediatrician and two nursing consultants—one trained and experienced in maternity care and the other in pediatrics. In addition to giving individual consultation to hospitals, the maternal and child health staff conducted regional institutes on maternity and newborn care

Based on a paper presented at the 1959 annual meeting of the American Public Health Association.

and prepared two manuals, "Recommendations for Hospital Nurseries" and "Recommendations for Hospital Maternity Departments," which had wide distribution. The division also collaborated with leading pediatricians in the State and with industrial engineers in the development of an inexpensive, efficient incubator.

In the mid-forties, the wartime Federal Emergency Maternity and Infant Care program gave impetus to the State's hospital consultation program by devising a sliding rate of payment whereby the per diem rate paid any hospital for the care of EMIC patients was based on the hospital's compliance with certain requirements considered basic to the safe care of mothers and newborn infants. These requirements were: individual equipment for mothers and for infants; terminal sterilization of formulas (sterilization of the milk after bottling); adequate hand washing facilities; and adequate maternity department staffing.

A major change occurred in the hospital consultation program in 1951 when the responsibility for licensing hospitals with maternity departments was transferred to the State department of health from the State department of public welfare. Although the maternal and child health staff was somewhat afraid that the licensing responsibility might interfere with the excellent relationships which the department had built up with hospitals throughout the years of consultation, these fears have not been realized. On the contrary, the licensing function has strengthened the hospital consultation program while the department's years of experience with consultation has helped to play down the "policing from above" which is too often inherent in licensing programs.

When the licensing program began, the department decided to give the hospitals reasonable periods of time to comply with the rules; and to increase gradually the number of rules requiring "immediate compliance" for full license while providing advice on how to meet the requirements efficiently as well as economically and practically.

The Michigan "Rules and Minimum Standards for Hospitals" include 180 individual regulations. With the advice and guidance of the health commissioner's hospital committee the rules have been divided into three categories: (1) those requiring immediate compliance; (2) those requiring compliance within a planned period; and (3) those with compliance time undesignated. These last will be placed in the planned or immediate compliance categories at times when this seems reasonable for the majority of hospitals.

In 1951 in order to qualify for a full license hospitals had to comply immediately with only four rules. These required individual equipment for mothers, individual equipment for babies, running water in the nursery, and provision for sterilizing the babies' formulas. During this first year of licensing only 56 percent of the hospitals in the State qualified for a full license. Eight years later, in 1959, although the list of 180 rules included 124 requiring immediate compliance, 90 percent of the hospitals in Michigan had full licenses.

### *The Program*

At present major responsibility for hospital consultation, licensing, and certification in Michigan is carried by the hospital consultation and licensing section of the State health department's maternal and child health division. This section consists of a physician director, four nursing consultants, two part-time sanitary engineers with master's degrees in their specialty, and two clerks. While the section is small, it has available at all times the services of the large number of specialists on the department's staff who have a variety of responsibilities within the department's total program—epidemiologists, pediatricians, obstetricians, laboratory scientists, dietitians, ventilation and radiological engineers, statisticians, and others. The section's staff has been stable and has achieved good rapport with the hospitals. We have found it important for the team to be directed by a physician, preferably one with experience in private practice as well as public health, because a physician not only understands hospital problems and what patients in hospitals need but also has status with the administrators and medical staffs of hospitals.

For administrative purposes the section has divided the State into four regions, with a nurse assigned to each region. All of the nursing consultants have master's degrees but in different specialties: maternity nursing; consultation, with emphasis on maternity care; pediatric nursing; and nursing administration. They also have all had years of supervisory experience in hospitals, which helps them to understand hospital administrative problems. The differences in the nurses' specialties help them to function as a team, for they all receive the benefit of the others' counsel, informally in staff meetings, and, in field consultations, when they call



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each other into their respective regions for assistance with special problems.

As nursing consultation regarding patient care, hospital facilities, and equipment demands highly specialized skills, our hospital nursing consultants give direct service to all hospitals without any assistance from the nurses of local health departments in all areas except Detroit. In Detroit a nurse employed by the city health department works in close cooperation with the State consultant assigned to the metropolitan area.

However, since many of the problems in hospital sanitation are similar to the problems local health departments help other large institutions to solve, qualified sanitary engineers on the staffs of all the large local health departments and a few of the smaller departments have accepted major responsibility for the sanitation consultation and annual licensing visits to hospitals in their jurisdictions. The State sanitary engineers give individual and group consultation to the local engineers and take responsibility for direct service to all hospitals not served by sanitary engineers of local health departments.

In our program the different consultants usually visit hospitals separately for the annual evaluation or licensing visits as well as for special consultation, but the physician, a nursing consultant, and the sanitary engineer also make joint visits frequently to discuss situations needing adjustment with the hospital administrator and staff. When infection breaks out in a hospital, the department's epidemiologist heads the study team and has top priority for the services of the regional nursing consultant and the sanitary engineer.

The length of consultant visits varies from a half hour to a week or more. A licensing visit usually takes a day, involving as it does a detailed evaluation of the hospital to determine compliance with the State's 180 rules or minimum standards. When infection has been reported in a nursery for newborns, the nursing consultant dons her uniform and goes into the hospital, often to spend several days observing the techniques used on all three shifts. A visit in response to a new hospital's request for help in setting up procedures and routines may last a week and may involve two nursing consultants, one working in the maternity department and another helping in central supply or another department.

Annual licensing visits are made by appointment only but many followup visits and some consultation

This mobile bassinet in a modern hospital may be hooked to the mother's bedside. While bassinet mobility is not a requirement in the Michigan licensing program, the provision of individual equipment for infants and for their mothers has been a requirement since the beginning of the program.

visits are made without appointments. Hospital administrators and supervisory personnel often ask the nursing consultant to stop by whenever she is in the area. Such casual visits are often the most productive, especially when the nurse happens to come at a critical, and thus opportune, moment and is bombarded with questions and requests.

Consultants discuss their observations with the hospital administrative personnel before leaving the hospital and later prepare a written report for review by the section chief and transmittal to the hospital administrator. Included in the section's annual evaluation summary for each hospital is a listing of (1) violations, if any, (2) recommendations, and (3) improvements noted since the previous visit.

The consultation team informs the hospital administrators and staffs of services available from other consultants in the department. As a result, the department receives requests for help of various kinds—with the development of obstetric policies, educational programs, or record forms, with planning kitchen layouts, or with the solution of ventilation problems.

### *A Cooperative Venture*

We have found that leading practicing physicians and hospital administrators and nurses will give

eagerly and generously of their time and ability to help a governmental agency with the development of standards for hospital care.

The department's document, "Rules and Minimum Standards for Hospitals," was drawn up by the staff of the hospital consultation and licensing section and revised according to suggestions from the maternal and child health division. Selected sections were prepared in cooperation with, or cleared by, the directors of the department's other divisions or its specialists in sanitary engineering, acute communicable disease control, chronic disease, laboratory services, nutrition, health education, public health nursing, records and statistics, and industrial health. After clearance by the office of the State health commissioner, working drafts of the document were sent to about 100 persons: All members of the commissioner's hospital committee; the Michigan State Medical Society's maternal health and child welfare committees; the trustees of the Michigan Hospital Association; the Michigan Osteopathic Association and the Osteopathic Hospital Association; departments of obstetrics in the two medical schools within the State; schools of nursing in three State universities; and local health departments; as well as to many individual physicians, hospital administrators, and nurses. The suggestions received were correlated, and most of them adopted.

As a result of this procedure:

- The department received the benefit of advice from Michigan authorities in the field of hospital care.
- Organizations and individuals shared in the development of standards for their work.
- The final standards were higher than those which the State health department had originally thought feasible.
- Representatives of medical, hospital, and nursing organizations, and other individuals in influential positions in their professions, read the rules and standards word for word. Because they were thoroughly familiar with them, they later served as the best interpreters of them and of the State health department's objectives in setting them up.

In order to answer questions that hospital staffs had raised about the program's rules and minimum standards and to indicate various ways of complying with an individual rule, the maternal and child health division prepared a hospital manual. When the division was not able to keep up with the demand for copies of the whole manual or parts of it, many hospital administrators and nursing directors had sections of the manual duplicated for their use. An appendix including 40 exhibits has proved to be especially helpful to the hospitals. It includes information on many subjects, among them illumination, laundering, sterilization equipment, dishwashing, food, sterility tests for infant formulas, control of infection, eye prophylaxis, methods of formula preparation, suggested policies for obstetric departments, nursing and dietetic personnel, maternity and newborn record forms, and many other subjects, with a suggested bibliography.

### *Educational Emphasis*

The major emphasis in Michigan's program for achieving a high quality of hospital care is placed on education.

Scholarships financed with Federal maternal and child health funds are made available to hospital maternity and pediatric nurses for accredited training at the graduate level and for non-accredited training at universities outside the State, such as short courses on premature care at Cornell University or the University of Colorado.

The maternal and child health division annually co-sponsors short courses with one or more of our three State university schools of nursing on subjects such as premature care; emotional aspects of hospital care of children; better care of maternity patients through better teaching of patients.

Each year the maternal and child health division holds several regional 2-day conferences for professional and practical nurses and nurses' aides working in hospital maternity departments. One hospital serves as host to personnel from a half dozen neighboring hospitals. Leading local physicians and nurses and State health department physicians, nurses, and sanitary engineers serve as the faculty.

The section's staff and other appropriate consultants also review plans for all hospitals to be built with Hill-Burton funds within the State as well as for many other hospitals.

The physician in charge maintains close working relationships with the children's division of the State department of social welfare in checking on any hospital participation in adoption procedures.

Staff members of the maternal and child health division and the statistical methods section work with hospitals on perinatal mortality studies. Improvement in maternity department records and an increase in the percentage of autopsies have been noteworthy results of these studies.

*A multidisciplinary team in an Iowa research project uses . . .*

# A HOME ECONOMIST IN SERVICE TO FAMILIES WITH MENTAL RETARDATION

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FOR THE PAST YEAR a home economist at the State University of Iowa has been a member of a research-oriented multidisciplinary team providing services to a selected group of families in which at least one parent and one child appear to be mentally retarded. The families are being "saturated" with a variety of services in an effort to determine the relation of social, economic, and educational deprivation to familial mental retardation—retardation occurring throughout a family without any apparent organic cause—a phenomenon which seems to be peculiar to families of low socio-economic status.[1] In this study, known as the Pine School Project, an attempt is being made to learn whether the alleviation of deprivation through services brings about improvement in the measurable intelligence and functioning of the members of such families.

The project is a cooperative undertaking involving two State agencies, the health department's division of maternal and child health and the welfare department's child welfare division, and the following units of the university: the child development clinic in the department of pediatrics, the department of home economics, the college of education, the Iowa Child Welfare Research Station, the department of psychology, and the school of social work. It is being conducted by the staff of the child development clinic. (See CHILDREN, January–February 1959, page 35.)

These children and their families were initially seen in 1957 by the clinic's staff, which at that time consisted of a physician, a psychologist, a social worker, and an educator. They were provided with a complete team evaluation and followup care. Gradually it became obvious to the staff that in the followup services large areas of family life were being neglected, such as interpersonal relationships, methods and attitudes of child care, family feeding, money management, homemaking, and health and cleanliness practices. Therefore, a home economist and a public health nurse were added to the staff.

The home economist was charged with finding ways of helping the families to improve their home life and of studying the effects of the methods she devised. The assumption was that these families could be motivated to improve their conditions, that

The author acknowledges the cooperation of the other members of the child development clinic in the preparation of this manuscript. They include: Robert B. Kugel, pediatrician; Theron Alexander, psychologist; Marlin H. Roll, educator; Harry B. Brown, social worker; June L. Triplett, public health nurse.

they could be encouraged to learn methods and techniques for doing so, and that the mentally retarded children would benefit from the efforts of their parents to achieve an improved home environment, especially if these efforts were successful. The home economist's services were envisaged as primarily supportive and educational, with the goal of teaching mothers to recognize and to solve their homemaking problems.

### *The Families*

At the beginning of the study 18 children of preschool age, diagnosed as being familially retarded, were enrolled in the project's experimental day school, the Pine School. They were selected from nine families meeting the following criteria:

1. The child and at least one of the parents must be diagnosed as mentally retarded, with no apparent organic involvement, the child's IQ being somewhere between 50 and 80.
2. The family's status in society must be in or near the lower socio-economic group.
3. The families must reside in Johnson County, Iowa.
4. Parents must be living together at the onset of the study.

Ratings by the Warner scale of socio-economic levels[2] placed seven of the families in the lower-lower socio-economic group. The other two families fell between the lower and upper-lower levels. All of the fathers were unskilled laborers except one man who was a foreman in an ice cream factory and regarded as "semiskilled." Only one set of parents had had a high school education. None of these parents participated in any community activities, or attended church.

Though not completely dependent, these families relied on the county welfare agency for food coupons, clothing, and financial assistance when emergencies arose. When they purchased any clothing they usually did so at a 5-cents-to-$1 store or at a supermarket. However, they secured most of their clothes and bedding through donations from individuals or organizations. Most of them bought their food at supermarkets; two families maintained charge accounts at neighborhood stores.

All but one of the families lived in substandard housing. With two exceptions the houses were heated by parlor stoves. Three of the homes had no inside running water. None had adequate sleeping quarters. Most of the furniture, either bought or donated, was secondhand. Refrigerators and stoves, however, had usually been purchased new on a payment plan.

In only two homes were there enough dishes, silverware, and chairs for everyone in the family to be seated at once to have a meal together. Sheets and pajamas were not considered important, except in two homes. Rags usually took the place of dish cloths and bath towels. There were no rugs or vacuum cleaners.

All of the families had some type of a washing machine and rinse tub. Nevertheless their clothing was not usually clean, even after washing, because of the problem of carrying and heating enough water for a large family washing. Most of the homes were without basements, so that the only place available to dry clothing in bad weather was in the living room or kitchen. These rooms were small.

Three of the families had telephones, and all but one a TV set and an automobile. Most of the families lived on the outskirts of town or in the country.

### *First Visits*

The home economist's first step in working with these families was an effort to establish rapport. To accomplish this, she visited each family with the social worker and told the mothers about the kinds of services she had to offer. She followed each initial visit with three more "get acquainted" calls, a week apart, during which she tried to learn something of the mothers' interests and abilities as possible levers for motivating them to improved functioning.

Two facts became apparent from these early meetings: (1) that these mothers were lonesome people, cut off from society, and (2) that they wanted to learn how to make their homes more livable.

Some of the mothers showed immediate enthusiasm when the home economist offered to teach them to sew, clean, plan meals, and prepare food. Others expressed mild interest, and one was almost totally unreceptive.

As soon as the home economist achieved rapport with the mothers, she found her services in demand. Two other members of the staff—the public health nurse and the social worker—were also receiving heavy demands for followup services from the families. Therefore, these three staff members decided to divide the responsibility for maintaining regular contact with the families. Under the plan each family would receive at least one home visit a week from one of these workers. If an emergency arose requiring the skill of a worker not assigned to the family, that worker would be called in.

Several times during the ensuing year all three workers found themselves concentrating on a particular problem of one family. At other times two of the workers were doing so. When the special problem was solved, the responsible worker continued calling on the family every week.

This plan to coordinate the efforts of nurse, social worker, and home economist created no professional jurisdictional problems. The home economist often found herself listening to a woeful story involving a health or social problem, but she made no attempt to deal with it on the spot, except to say that she would send the social worker or the public health nurse out to call. After a staff conference the appropriate staff member would go into the home and try to help solve the problem. Each discipline represented remained distinct: each worker had more than enough to do.

The loneliness of these families was unmistakable. They did not participate in groups such as parent-teacher associations, women's clubs, or church groups, either because they felt inadequate or because they had tried in the past and had a painful experience which they did not wish to repeat. Most of them had no close friends; their relationships were principally within their immediate families.

The staff believed that a group organization might fill the mothers' need for companionship and also serve as a teaching medium for the home economist. Therefore, the home economist took a two-pronged approach individual and group—in providing services.

### *Work With Individuals*

Three families were assigned to the home economist. Each had asked for help on many homemaking problems. The home economist visited each family once a week at unscheduled times—unscheduled to stimulate the mother to keep her house in order at all times. She began by attempting to find out what problem in homemaking was causing the mother the most concern and to help her make plans for a solution that would not require a large outlay of money and that seemed to be achievable. She gave the mother suggestions but left her with the responsibility for carrying them out, calling back at appropriate intervals to discuss progress, and to lend her support and encouragement.

Once—but only once—the home economist made the mistake of taking up with the mother a community criticism of the family. The mother immediately withdrew and became defensive, and the good rapport the home economist had so painstakingly established was nearly lost.

### *The Greens*

The first family selected for the home economist's concentrated attention, whom we shall call the Green family, consisted of a mother, a father, and 10 children. The father, who was employed on the section gang of the railroad, was considered a reliable and willing worker. However, he drank heavily on week ends and gambled. Ever since his marriage he had been sent to the county jail three or four times a year because of drunkenness and for mistreating his wife. The mother was overweight, but otherwise pretty. From the time she was 6, when her mother died, she had been in one foster home after another, never being fully accepted or loved. At 16, she had been persuaded by her father, who did not approve of her current love affair, to marry a man much older than herself. She has never forgotten her teenage love.

The Greens had received help from the county welfare department most of their married lives, as had their parents. They lived near the railroad tracks in a dilapidated dwelling, inadequate in rooms, furnishings, and health accommodations.

In 1957, the Greens' 10 children had been made wards of the court, and shortly afterward the two older boys were sent to different State institutions for the mentally retarded. The four girls still lived at home and were attending the public schools, but two of them were failing in their school work, and the other two were in special education classes. Of the remaining four children, all boys, three were attending Pine School, and the youngest, who was subject to convulsions as well as being retarded, did not attend school. All the children were attractive looking, but they were always dirty, ragged, and unkempt.

On her first visit to this home the home economist found living conditions almost unbelievably bad. Food-encrusted dishes were on the tables; food which had previously been spilled on the floor had been allowed to accumulate and spoil; broken pop bottles and beer cans were sitting about; the furniture was broken and covered with dirty quilts. Two windows were broken and, since there were no screens, the house was full of flies. Dirty clothes were scattered in confusion about the rooms, and a fetid odor permeated the house.

Without making any reference to these conditions, the home economist called on the family at

least once a week as she looked for strengths to build upon and established a relationship with the mother—a process that took four visits. As Mrs. Green gradually realized that the home economist was not going to find fault with her or demand something from her, she began to show an interest in food purchasing and preparation. The home economist used this interest as a strength to build on, and with consultation from the social worker, tried to formulate simple, realistic goals that Mrs. Green could be encouraged to meet. Since Mrs. Green had exhausted her credit at the small, expensive neighborhood store where she bought her groceries, a discussion of food buying and planning was selected as a starting point. In a very short time Mrs. Green asked that the home economist help her to plan her meals for a week and to make out a market order. The social worker and the nurse, both of whom were also visiting the family, also supported Mrs. Green's efforts to plan. Now she plans by the week and purchases at a supermarket most of the time.

After some time the staff could not help but notice the improvement in the mother's housekeeping. When the home economist arrived on her unscheduled visits, dishes were usually done, the floor scrubbed, and the dirty clothes put out of sight. The interest being shown in the family by the staff and their noncritical attitude seemed to motivate the mother to greater effort.

Whenever Mrs. Green mentioned the possibility of improving some area in her home, the home economist showed an immediate interest. When the mother expressed a desire to paint and fix up the living room, she arranged for the paint to be purchased through a gift fund available to the child development clinic. Mrs. Green painted the room herself and was very proud of her accomplishment. She then saved and bought some plastic curtains for the windows and replaced the broken window panes. This show of interest and activity was a great surprise to everyone.

This family has been served by the project for 2 years, and the home shows definite signs of improvement. There are periods of backsliding, especially when Mr. Green is on one of his periodic drunks, but in general, the family does not go back as far as the state of apathy it was in when first visited by the project workers.

The two boys who were enrolled in Pine School are now attending public schools. While the next-to-youngest boy still needs to attend Pine School, he has learned to talk and express himself, which he could not do before. While these children are still retarded, the project staff believes that they can see some improvement and will be able to see more in the next 3 years.

### *The Marnes*

The second family selected for the home economist's concentrated help—called here the Marne family—consisted of a father, a mother, and five girls. The youngest girls, twins, attended the Pine School. The older girls, 8, 9, and 10, attended the public school special education classes. This family had the kind of housing and equipment usual in lower middle-class families, but their attitudes and income defined them as of lower socio-economic standing.

Mr. Marne, a responsible foreman in an ice cream factory, had become an orphan at an early age and had been passed from one home to another, finally ending his childhood in the city orphanage. He joined the Navy as soon as he had finished the eighth grade, and had never gone back to school. Mrs. Marne also had had a very deprived childhood. Her parents had had a large number of children and had frequently received public assistance. They had worked their children very hard around the home and had taught them the elements of cleanliness but little else. Mrs. Marne took the same attitude toward her own children. The girls were attractive looking, but often unkempt and shabbily and inappropriately dressed.

The relationship between Mr. and Mrs. Marne was stormy. Although Mr. Marne made a steady income, he would not trust Mrs. Marne with any of it.

Mrs. Marne was immediately receptive to the home economist's offer of help. There were so many things she wanted to learn that the home economist had difficulty pinning her down to one achievable goal. However, she eventually decided to learn to clean house for others, so that she might have some money of own to spend.

Realizing that the houses in which Mrs. Marne might find work would be more elaborate than her own, the home economist took her into her own home once a week to teach her a variety of housekeeping skills. Mrs. Marne obviously wanted to learn, and she did learn rapidly although her intelligence test had produced one of the lowest scores in the project. After 6 weeks of this arrangement, the social worker suggested that Mrs. Marne be encouraged to seek

employment as she now had the skills she had set out to learn and was in danger of developing a dependency relationship to the home economist. Though the home economist helped her find her first job, at present she has several cleaning jobs which she secured by herself and which fit her children's school hours. The reports of her work are good.

Mrs. Marne also asked for help on planning and marketing for the family's food. Breaking into tears she told the home economist that Mr. Marne was tired of her routine fare and refused to come home for meals. The home economist responded by helping her to plan a week's menu and market order built around the kinds of foods her husband liked. Learning that Mrs. Marne did not know how to use a cookbook, although she owned three, she also showed Mrs. Marne how to follow a recipe. Mr. Marne now seems to enjoy eating at home and Mrs. Marne is continuing to try new dishes.

After 2 years of service the Marne family shows great improvement. Through contacts made in her housekeeping jobs, Mrs. Marne has become aware of how other people live. Consequently, the children are now having their hair brushed and combed, and their dresses altered to fit them. Their mother has encouraged them to join the "Brownie" Scouts, to attend Sunday school, and to have parties. The two youngest girls have moved into a public school and seem to be doing well. In spite of her low IQ, Mrs. Marne has a tremendous drive to improve her family.

### *Group Meetings*

Because of the obvious loneliness of the women being served in the project, the home economist decided to try to get them together in group meetings. She saw the possibilities of using the meetings not only to alleviate the mothers' loneliness but also to help them learn more about meal preparation and food planning, sewing, child care, housekeeping, and personal cleanliness. Approaching some of these subjects with groups rather than with individuals would be less likely to wound personal feelings. If the women took turns in having the group meet at their homes enough competition might arise to serve as a motivating factor for "sprucing up" their homes. The meetings might also be used as a means of introducing the young children of these families to one another and giving them some opportunity for social interactions. The home economist hoped that each time a woman had a meeting in her home and had to cope with the various problems of entertaining, the experience would add to her ability to accept responsibility.

Because of her energetic, outgoing nature, Mrs. Marne was asked whether she would like to form a social group of the women whose children went to Pine School. When she responded enthusiastically, it was suggested that she bring the idea up at a Pine School PTA meeting. Meanwhile, the home economist also planted the idea of a social group with other mothers in the project. Thus, when Mrs. Marne made the suggestion at the PTA meeting the mothers accepted it readily because they were familiar with it.

There was never any difficulty in selecting a meeting place, as each woman in the group seemed anxious to entertain.

At each meeting the hostess furnished the necessary dishes; another member of the group brought refreshments having volunteered to do so. These have ranged all the way from good and attractively decorated sandwiches to a poor pumpkin pie. Before each meeting the home economist checked early in the week to see if she could be of assistance to the hostess and to the woman bringing the refreshments, and to make sure that they had not forgotten that they were to serve. She also sent notes to all the mothers reminding them of the meeting. No one ever forgot.

These meetings were obviously very important to these mothers. Only once, at a time of extremely bad weather and a measles epidemic, was more than one mother missing. Each meeting day, the public health nurse and the home economist made the rounds in their cars, picking up children and their mothers who had no other way to get there, and taking them to the home of the party hostess. Only one woman in the group could drive a car at the beginning of the program. Since then, four women have learned to drive.

With suggestions from the public health nurse and the mothers themselves, the home economist has planned the program for these meetings. For the first meeting she selected an activity that would be fun without posing any threat to the mothers. She brought dried weeds to the meeting for the mothers to paint and to make into winter bouquets. At first the women were diffident about trying, but soon were painting away enthusiastically. The bouquets were in evidence in some of the homes all winter.

At the next two meetings, the mothers decorated quilts for naptime use at the Pine School. Activi-

ties at subsequent meetings have included a recipe exchange, a demonstration by a mother of how to make baking-powder biscuits, a discussion of washing techniques, a demonstration by the home economist of sewing techniques, and a discussion of how to get inexpensive ascorbic acid into diets. This last subject was chosen because nutrition surveys showed the diets of these families to be low in ascorbic acid value.

The Pine School staff had found that many of these mothers were not able to tell when a child was too ill to attend school. Therefore, one meeting was devoted to simple health instructions. The public health nurse showed the mothers how to read a thermometer, told them what a temperature meant, and gave suggestions on how to tell whether a child was too ill to attend school.

One meeting followed a showing of a child development film at the Pine School PTA meeting and was devoted to a discussion of child rearing. The women were shown government bulletins on child care for different ages and were given those in which they were interested.

In spite of these serious discussions, the meetings are essentially of a social nature. The time devoted to discussion has purposely been kept short because of the shortness of the mothers' attention spans and because the children are likely to be noisy.

### *A Sense of Status*

Being a member of a group has given these women a sense of belonging. Probably the most important outcomes of the meetings for them have been the attainment of friendships and the development of a sense of status within themselves. As they have gained in stature in their own eyes, they have tended to become more adequate. The competition that is usually found among the members of any group has begun to appear. The women have tried to dress as well as their friends, have the house as nice as their friends' houses, and be as clean as their friends.

One of the most unreceptive women in the project has learned through the group meetings to accept the services that the project staff has to offer. She has attended each of the meetings, accepted medical assistance, and asked for help in learning how to sew. Both she and her husband have begun to attend the Pine School PTA meetings and have made friends there. She has exchanged babysitting services with other women in the group. This woman and her husband had once had their 10 oldest children removed from their home by court order for being incompetent parents.

Another woman, who used to be described as slovenly, now takes great pride in her appearance as well as in the appearance of her children and her home. She and her family have moved from a dilapidated shack in town to a larger, more adequate house in the county, which she has fixed up with donated curtains and a few purchases. Her husband has been able to work out the rent by helping the farmer who owns the house. The family keeps the home neat and tidy, despite the fact that the mother must carry water for some distance.

A closely knit group can be a powerful force in an individual's life. Such a group might be difficult to organize without a nucleus to start with such as the Pine School PTA. To the home economist it seemed important that the idea of a group organization should develop through one of the mothers, and that transportation to the meetings should be provided since they were afraid of a new experience. Other ways might be tried and found to work equally well.

How much the awakened interest of these parents in their homes has affected their children is difficult to judge. However, we can make one observation: When six of the younger children of the Pine School project reached the age of eligibility for attendance at the school and their psychological tests were given, only one of them tested low enough to meet the criterion for admission. This is merely an observation, but it raises the question: Could there be a relationship between the stimulation of the parents and Pine School brothers or sisters and the fact that these children had higher IQ scores than their older siblings?

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[1] Masland, R. L.; Sarason, S. B.; Gladwin, T.: Mental subnormality. Basic Books, New York, 1959.

[2] Warner, W. L.; Meekner, M.; Eells, K.: Social class in America. Peter Smith, Gloucester, Mass., 1957.

*How a public welfare department initiated steps that led to . . .*

# WINNING A VICTORY FOR EMOTIONALLY DISTURBED CHILDREN

DOROTHY WAITE

*Director, Division for Children and Youth, Wisconsin Department of Public Welfare*

ON DECEMBER 5, 1957, one of Wisconsin's crusading newspapers printed the following paragraph in a column by the editor:

> Officials of the State department of public welfare are planning to carry on a campaign during the coming 2 years for the establishment of a treatment center for emotionally disturbed children. The welfare department will bring this matter before the next session of the legislature. The campaign is already started among several interested groups over the State who seek a better understanding of the problem when it is brought before the next legislature. Emotionally disturbed children? Who is going to lobby for them?

Two years later the Wisconsin Legislature *did* establish a treatment center for emotionally disturbed children as part of a broad mental health program. This article will describe who *did* lobby for these children, and how it was done.

In Wisconsin social services for children have developed along the same lines as in many other States. Thirty-eight voluntary agencies provide services to children, 32 maintaining and operating institutional programs. In addition, two public agencies give direct services to children, one in the Milwaukee County Department of Welfare and the other in the Wisconsin State Department of Public Welfare. Both of the public agencies operate small institutional programs caring for dependent and neglected children, but the majority of the children in their care are served in foster homes. Social service and psychiatric consultation have been available in varying degrees in both voluntary and public programs.

In the postwar years it became apparent that the needs of some of the children known to these agencies were not being understood or met. Many of the children were severely neurotic; some had been adjudged delinquent and were already in State institutions where they did not seem to fit. In 1945 the Wisconsin Legislature had authorized the establishment of a State diagnostic center for the study and diagnosis of child and adult patients in State hospitals and institutions. The center, opened in 1954, is operated by the division of mental hygiene of the State department of public welfare. About a year after it opened, a law was passed to permit the direct admission of children referred from the juvenile court for screening services to determine the type of treatment facility needed by each child. There was some apprehension at the time lest diagnosis would only point up the need for treatment facilities. This prophecy actually was realized, but served as a positive force toward getting the need met, at least in part.

Other public mental health programs which directly or indirectly were affecting the well-being of children included the interdepartmental commission on mental health, established by the legislature in 1946 to coordinate the activities of the State board of health, the State department of public instruction, and the State department of public welfare. The functions of this commission were (1) to distribute Federal mental health funds and (2) to

Based on a paper presented at the 1959 round table conference of the American Public Welfare Association.

determine effective ways of carrying out programs for mental health in the State.

The State hospitals for the mentally ill, under the administration of the division of mental hygiene of the State department of public welfare, although established for the care of adult patients, were housing a few children for lack of any appropriate facility. In 1952 a child psychiatry unit was established in the University Hospital in Madison.

Fifteen child guidance clinics financed from local, State, Federal, and community chest funds and private fees had been developed in various communities between 1926 and 1956, as the result of clinic demonstrations by the State board of health, to treat children and parents who were struggling with various degrees of emotional difficulties.

Excluding the services of the diagnostic center and the University Hospital psychiatric unit, these clinics on the average each had the services of a psychiatrist available for about 3 days a week.[1]

To the professional persons working in these State and local child welfare and mental health agencies the need for a tax-supported facility for the intensive treatment of emotionally sick children became increasingly clear. But it was also clear that the high cost of care would prohibit the State from making more than a modest beginning.

### *First Steps*

The earliest moves toward securing such service were made by the State division for children and youth and the Community Welfare Council of Milwaukee County.

• In April 1954 the division for children and youth, through its advisory committee, called together representatives from the voluntary child serving agencies, presented to them the results of a study of 312 children in which 55 children were recommended for intensive psychiatric treatment, and asked whether the voluntary agencies could share the responsibility for serving these children. The voluntary agencies gave their full support to the suggestion of asking for a tax-supported facility, and at the same time agreed to examine their own programs and intake policies in an effort to provide this type of service. Since then six of the voluntary agencies have begun accepting seriously disturbed children for intensive treatment.

• In a report to the State department of public welfare on May 14, 1954, the division for children and youth recommended "that the establishment of an intensive treatment center be studied for the purpose of submitting a practical plan, giving consideration to location, costs of construction, and efficient operation."

• On May 18, 1956, the Community Welfare Council of Milwaukee County reported on a study of 645 emotionally disturbed children, which found that the treatment needs of 84 percent were unmet and that 121 children were in need of treatment and care in a residential center. This report recommended that both the Milwaukee County Board of Public Welfare and the State department of public welfare consider the development of such facilities.

• In September 1956 the division for children and youth in a report on long-range plans to the State board of public welfare again called attention to the 1954 study of 312 children and urged consideration of plans for a treatment facility.[2]

These moves stimulated a number of lay organizations to call the needs of these children to the attention of the general public.

• The State league of women voters assigned one of its members, a writer, to gather facts for statewide distribution. A psychiatrist was invited to describe the situation for the league's magazine.

• The Wisconsin Association for Mental Health adopted the proposal for a public facility as a priority need. The association held meetings on the subject, printed a pamphlet called "Give Them a Chance," and actively lobbied when a bill was eventually introduced.

• The Wisconsin Welfare Council listed the need for a treatment center high among its legislative proposals and publicized the need through speeches and written materials.

• Other groups, such as the psychiatrists' and psychologists' professional associations, the American Association of University Women, community welfare councils, the National Association of Social Workers, and church organizations, conducted meetings and distributed literature.

### *Legislation Introduced*

Support for the proposed treatment center was approved by the State department of public welfare in February 1957, and on the request of the State department of public welfare a bill to establish the center was introduced to the State assembly on March 20, 1957. The bill, which was referred to the assembly's committee on public welfare, carried a fiscal note (required by Wisconsin law) explaining that on passage the sum of $875,000 would be requested of the State building commission. The note

also explained that the facility would provide for about 50 patients at a yearly cost of $8,000 to $10,000 each, an estimated annual expenditure of about $500,000 per year.

The concreteness of the bill spurred both professional and lay groups to more activity. Opposition forces and substitute plans began to appear, including proposals for school operated "dormitories" for counseling and treatment and for using a wing for children in State, county, or private hospitals. In each instance, one of the bill's supporters managed to explain personally to the bill's opponents the weaknesses in the alternate proposals and to gain support for the bill.

Nevertheless, the bill failed to be reported out favorably by the joint finance committee of the 1957 legislature. Gains were, however, made in this period. The only public hearing the bill ever had was held in April 1957 by the assembly's public welfare committee. It lasted about 3 hours, most of the time being taken by the bill's proponents—executives and board members of voluntary child welfare agencies, State officials, representatives from the PTA, the Wisconsin Association for Mental Health, the Wisconsin Welfare Council, the League of Women Voters, the American Association of University Women, psychiatrists, county boards, the Council of Jewish Women, the Council of Catholic Women, and others. The agency representatives presented actual case stories to obviously moved committee members. State officials told of the financial burden these children represented for local communities, schools, and the State correctional, charitable, and mental institutions, explaining that these institutions could do little for them.

Only one person appeared in opposition to the bill, a man representing the Economy League. Obviously affected by the testimony of the bill's proponents, he stated simply that he fully understood the need for the proposal but hoped a more economical solution could be found. The public welfare committee voted 7 to 1 for the bill.

When the joint finance committee began to consider the bill in late June 1957, it had already become evident that the high cost of the service per child would jeopardize its chance for passage. A State senator had already introduced a proposal to create under the administration of the legislative council a committee to study mental health programs for children and youth during the 1957–59 legislative interim. While this proposal would delay definite action for at least another 2 years, it was preferable to complete defeat. The bill to establish the treatment center died quietly in the last few hours before adjournment during efforts to avoid an income tax increase.

### *Legislative Interim Study*

The hearings in regard to the proposed interim study brought out the same supporters as those for the treatment center, but no opponents. Some of the legislators, now aware of the children's need, spoke publicly for the study. The proposal passed with little difficulty.

A great deal of important legislation has reached the statute books of Wisconsin through the legislative council, which was charged with making the study. This permanent factfinding body, created in 1947 to examine important subjects for the legislature between sessions, consists of 15 legislators, 9 from the assembly and 6 from the senate. It holds regular meetings and has authority to appoint committees to conduct and direct studies of particular subjects. These committees may include members of the public who are particularly well informed in the field to be studied. The council is authorized to make surveys and studies and to compile data, information, and records on any question referred to it, to make recommendations for legislation or administrative action, and to introduce bills designed to carry out its recommendations.

During the 1953–55 interim the council had made a study resulting in a recodification of the State laws affecting children. In its final report it had recommended that future attention be given to treatment programs for emotionally disturbed children, an area not covered in its study.

The interim study committee, created by the legislative council in 1957, included three members of the senate, three of the assembly, and three citizens who had "demonstrated knowledge and interest in the problems of mental health, programs for children and youth, and juvenile delinquency"; and, as nonvoting ex officio members, the heads of the State welfare department's divisions of mental hygiene and children and youth.

The committee appointed an advisory committee of persons with special knowledge and experience in the areas of its inquiry.

The broad duties of the legislative council committee were to "conduct a study of the problems of mental health and program for children and youth." The legislative charge was spelled out in some detail. It included evaluations of the State's

programs for the care of the physically handicapped and the mentally retarded, of health and hospital insurance coverage in the State, and of efforts toward delinquency prevention; and suggestions for improving the scope and degree of coordination of all State mental health services which are now provided by the departments of public welfare, health, public instruction, and vocational and adult education, "including evaluation of the programs for emotionally disturbed children. . . ." A report was required by November 1, 1958.

The committee held its organizational meeting February 10–11, 1958. It soon became obvious that the subjects listed in the law were too numerous to receive full attention in a single interim study. Deciding that the State faced major problems in relation to the mental health of children and youth, the committee assigned priority to:

1. The proposed intensive treatment center for emotionally disturbed children.

2. Improvement in the scope and degree of coordination of all State mental health services.

3. Methods of recruiting staff.

4. Alternate and supplementary forms of care.

5. Evaluation of community services for the retarded.

6. Methods of increasing health and hospital insurance coverage to provide for inpatient and outpatient treatment of psychiatric disorders.

7. Prevention of juvenile delinquency.

The committee approached the study through a variety of activities, including:

- Meetings to hear proposals regarding the establishment of a treatment center, the employment policies of State departments, health insurance coverage, and coordination of State activities for mental health.
- Field trips to institutions for neglected children, institutions for the mentally retarded, and State mental hospitals.
- Visits (by the committee chairman) to existing treatment centers in Connecticut and New Jersey.
- Delegation to the advisory committee of finding ways to coordinate all State mental health activities, including the problem of supervision of local child guidance clinics.
- Interviewing State personnel and representatives of private children's agencies, the university medical school, and professional organizations such as the State medical society, the State association for mental health, and associations of psychiatrists and judges.

Through its inquiries, the committee learned that 30 private residental treatment centers for emotionally disturbed children were in operation throughout the country; and that six States had established tax-supported and State-administered treatment centers. These were Connecticut, Illinois, Kansas, Michigan, New Jersey, and Ohio. Three other States, Delaware, North Carolina, and Pennsylvania, were in the process of establishing such institutions; one State, Minnesota, had passed enabling legislation, and two, New Hampshire and West Virginia, indicated the problem was under study. Wisconsin had no such institution either on a public or a private basis.

Because of the magnitude of the assignment, the committee did not have enough time to give full consideration to all its priorities. It therefore determined to concentrate on the coordination of the State mental health services, the recruitment of professional personnel, the provision of inpatient services for emotionally disturbed children and youth, and the expansion of outpatient services.

### *Committee Recommendations*

The final recommendations were intended to be viewed as a whole. Both before they were made, as well as during the active lobbying for and interpretation of the bill embodying them, the committee insisted that only the adoption of its three proposals together would accomplish its aim of making "a frontal attack on mental illness at all levels, and thus slow the march of the mentally ill to new institutions."

The three proposals were:

1. Construction of a treatment center for emotionally disturbed children.

2. Provision of State aid on a matching basis—for 40 percent State, 60 percent local—for the development of all-purpose mental health clinics around the State, to serve children and their parents as well as other persons in emotional distress. The clinics would be under direction of local mental health boards established by the State department of public welfare and an advisory committee to be appointed by the State board of public welfare. The clinics would be able to collect fees for service and to refer patients to private physicians for treatment.

3. The establishment of a State mental health advisory board to give constant attention to the State's needs in regard to mental health.

The bill embodying these provisions was adopted during the 1959 session of the State legislature.

At the same time the legislature authorized the State building commission to allocate an amount not exceeding $500,000 for the treatment center from the State building fund. Architectural plans are now being drawn up.

The companion program of State subsidized and supervised clinics has been moving forward rapidly. To date plans for 11 such clinics have been approved, while negotiations regarding two others are nearing completion.

### *Responsibility of Public Welfare*

It has been said that legislation is a process in which conflict, compromise, and cooperation all play a significant role. All of these forces were present in varying degrees in the Wisconsin experience and contributed to the final outcome.

The public and voluntary child welfare agencies worked together to present a united effort in interpreting the need. Though some fears were initially expressed that the creation of a public facility would detract from the possibility of achieving these treatment goals under voluntary auspices, these were quickly dispelled when evidence presented at a series of meetings called by the citizens' advisory committee to the department's division for children and youth showed clearly that neither public nor voluntary agencies could meet the need alone.

There were also ups and downs in the progress toward the eventual decision. Different points of view were presented by representatives of psychiatry, medicine, and public welfare on whether the residential treatment center they were proposing should focus primarily on research and education or on care and treatment for the individual. Representatives of the health field expressed the conviction that problems of mental health cannot be separated from other health problems: that all the machinery available to the public health field should be used to prevent mental and emotional disturbance. Representatives of public welfare readily agree to the importance of preventive endeavors but argued that prevention and treatment cannot be separated: that there is, in fact, no reason why an agency operating a treatment center could not also carry on a community mental health program with equal emphasis on prevention.

As early as May 1958, the proponents of the proposed treatment center reached agreement on its size, admission policies, and location, and the age range of patients. But the focus was still not settled.

At this stage, one of the voluntary organizations, the Wisconsin Association for Mental Health, exerted effective leadership in arranging opportunities for mutual understanding and agreement. The association also made sure that its local chapters were given information.

At the hearing of the proposed legislation before the senate public welfare committee, spokesmen for medical groups and hospitals urged that authority for selection and supervision of medical personnel and programs be given to the university in order to insure that training and research would receive necessary attention. The public welfare representatives recommended that the center be an integral part of the public welfare department's services to children.

At the hearing senators who were supporting the bill were obviously disturbed by these differences. A falling-out among proponents of the measure would endanger the entire project, which had failed of passage in the 1957 legislature.

The senators suggested that a solution to the problem be worked out by the board of public welfare and the medical school. This was done and an amendment brought to provide that the dean of the medical school submit a list of potential directors for the treatment center, from which the department of public welfare should make its choice.

The attention of the press to the bill reached a climax during this period, reflecting the growing concern and interest of the public. On the day the agreement was reached, every newspaper in the State reported the event—one with streamer headlines across page 1 announcing "Welfare Board and Medical School Reach Agreement on Child Treatment Center Plan."

The proposal for community clinics also encountered some last minute roadblocks in the form of controversy over whether these clinics be coordinated with the total mental health and welfare services of the State department of public welfare or be under the board of health, which had already initiated a number of child guidance clinics. However, when the legislative council committee determined that any newly established clinics should be all-purpose rather than child guidance clinics, the State board of health testified that it was not prepared to participate in a program of this type. The

committee concluded that the all-purpose clinics could be developed successfully under the department of public welfare, since it was the mental health authority for the State and had statutory responsibility for treatment and care of the mentally ill and for activities aimed at prevention of mental disorders.

In its report the committee observed that "as administrative organization for the hospitals becomes more exclusively the function of one department—whether it be welfare, health, or mental health—the more likely it becomes that the responsibility for community services is integrated into that agency." The report added:

> It appears that whatever administrative organization exists in the States, there has been discernible trend over the years toward centralizing authority for all types of mental health and hospital services. There is, on the other hand, an awareness of the fact that many agencies—such as health, welfare, corrections—are closely involved in State mental health programs. Coordination, therefore, becomes a major emphasis of organization.

Arguments against partisan or geographical interests had to be met. One was the suggestion that admissions to the treatment center should be controlled on a quota for senatorial districts. The press—ever present at the committee's sessions—was prompt to expose the weakness of this plan. Even newspapers in the locality from which the suggestion came ran an editorial against it.

The high per capita cost of running the center was one of the most serious obstacles to passage of the bill. No attempt was made to minimize the cost. Instead, proponents in the committee meetings and in legislative hearings predicted the serious consequences of inaction, and maintained that in spite of the expense, there was no alternative to the provision of this service.

The legislative council proved invaluable as a vehicle for most of the preliminary study, discussion, and recommendations. It not only provided a meeting ground for the representatives of the various State departments, but educated the six legislators who were constantly involved in the entire study to the point where they acquired a personal interest in the bill's passage and were equipped with the facts to enable them to speak effectively to other legislators.

### *Summary*

The observations that prompted these concerted efforts in Wisconsin could probably be made almost anywhere in this country today. They were:

- Greater numbers of children coming into foster care are presenting behavior or personality problems.
- Voluntary agencies are beginning to take steps toward providing treatment facilities, but there are many children for whom they cannot provide this treatment.
- Public child care facilities are receiving more and more referrals of emotionally disturbed children, and therefore have a responsibility to give these children the care and treatment they need.
- Emotionally disturbed children have neither the normal appeal to the public nor the lobby which is so readily at hand for other handicapped children. Leadership should and can be assumed by public child welfare people in informing the community about the types of care which are needed.

In Wisconsin we have learned that:

- A frontal attack on this problem is more effective if both public and voluntary personnel in the fields of child welfare, mental health, and education are able to arrive at a common goal and procedures for reaching it.
- Successful legislative action seldom comes until the private citizen acts, in his capacity as private citizen and as a member of organized groups. Only when citizens feel strongly about meeting a need will the need be met.
- Legislative research and study involving legislative leaders directly, preferably through a legislative council or commission, or by a specially appointed interim committee, is an effective means of assuring that the legislature understands the problem and the resources required to deal with it. Legislators tend to shy away from a complicated problem until their own legislative research bodies have had an opportunity to study it and make recommendations.

The success of our efforts indicates clearly that public welfare agencies can effectively stimulate action for securing the services needed to protect the mental health of children.

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[1] Wisconsin Legislative Council: Conclusions and recommendations of the committee on mental health and problems of children and youth. Vol. II, 1959 report.

[2] Wisconsin State Department of Public Welfare, Division for Children and Youth: Long-range plans; report to the State board of public welfare, September 1956.

# HERE AND THERE

## *Followup of White House Conference*

The new National Committee for Children and Youth, created to spearhead the followup efforts on the recommendations of the 1960 White House Conference on Children and Youth, has adopted a six-point statement of purpose. The statement was adopted on June 11, in Atlantic City, at the committee's second meeting since its establishment on the recommendation of the President's National Committee for the White House Conference by the Council of National Organizations for Children and Youth, the National Council of State Committees for Children and Youth, and the Federal Government's Interdepartmental Committee on Children and Youth. (See "Converting Words into Action," by Edward D. Greenwood, M.D., CHILDREN, May–June 1960.) The new committee's first meeting was held on March 26, just before the Conference.

According to the statement adopted in June the purposes of the committee are to:

1. Stimulate effective implementation of the recommendations of the 1960 White House Conference on Children and Youth and the widespread utilization of materials produced by the Conference.

2. Encourage cooperation and joint activities among the sponsoring groups.

3. Encourage the continuation and development of State committees on children and youth.

4. Promote and assist State, regional, and national conferences on the problems of children and youth.

5. Promote an exchange of information on concerns affecting children and youth.

6. Stimulate research and effective utilization of research findings in behalf of children and youth.

In carrying out these purposes, the committee proposed the use of all possible existing channels and especially those of the National Council of State Committees for Children and Youth, the Council of National Organizations for Children and Youth, and the Interdepartmental Committee on Children and Youth.

If the President's National Committee for the White House Conference meeting on September 19 approves the programs of the National Committee for Children and Youth, their implementation will be financed by residual funds from the White House Conference.

Members of the *National Committee for Children and Youth* are:

- *Members at large* (selected by the President's National Committee for the White House Conference): Mrs. Rollin Brown, Los Angeles; Luther H. Foster, Tuskegee Institute; Edward D. Greenwood, M.D., Menninger Foundation; Mrs. Thomas Herlihy, Jr., Delaware State Labor Commission; Roy Sorenson, YMCA of San Francisco.
- From the *Interdepartmental Committee on Children and Youth:* Edward W. Aiton, Department of Agriculture; Donald Harting, M.D., Public Health Service; Helen K. Mackintosh, Office of Education; Beatrice McConnell, Department of Labor; Katherine B. Oettinger, Children's Bureau.
- From the *Council of State Committees for Children and Youth:* Donald Brieland, Elizabeth McCormick Memorial Fund; Sylvia Carothers, Florida Children's Commission; A. Whittier Day, Minnesota State Department of Corrections; Mrs. J. A. Hill, Morristown, Tenn.; Donald S. Howard, School of Social Welfare, University of California at Los Angeles.
- From the *Council of National Organizations for Children and Youth:* Lyle W. Ashby, National Education Association; Robert E. Bondy, National Social Welfare Assembly; Nelson Jackson, National Urban League; Mrs. Douglas MacNeil, Girl Scouts of the U.S.A.; Philip Ryan, National Health Council.

An operating committee selected at the June meeting is preparing proposed bylaws inquiring into procedure for the legal transfer of funds, developing a staffing plan, and carrying the functions of a board pending the election of officers in September. Its members are Dr. Greenwood, Mrs. Herlihy, Mrs. Oettinger, Miss McConnell, Dr. Ashby, Mr. Bondy, Dr. Brieland, and Mrs. Carothers.

## *Federal Legislation*

Under a new law passed by the 86th Congress, the Secretary of Health, Education, and Welfare is empowered—in exercising his responsibilities in relation to health research under the act of 1912 creating the Children's Bureau and under other laws—to make use of resources for health research and research training in cooperating foreign countries. The purposes are stated in the law, the International Health Research Act of 1960, as (1) to advance the status of the health sciences in the United States, and (2) to advance the international status of the health sciences.

With respect to the Children's Bureau, the authority to establish and maintain fellowships and make grants is new, since the act creating the Bureau does not contain this authority. The law also contains provisions relating to the Public Health Service and the Office of Vocational Rehabilitation, both of which are already engaged in international health research activities.

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In an amendment to a House Joint Resolution concerning resettlement of refugees, the 86th Congress extended for another year the temporary provisions of an act passed in 1959, permitting certain alien children who have been adopted abroad by United States citizens or are to be adopted after arrival in this country to come to the United States on special nonquota visas. The new expiration date of this provision is June 30, 1961.

## *Day Care*

A National Conference on Day Care for Children will be held in Washington, November 17–18, 1960, under the joint sponsorship of the Children's Bureau of the Department of Health, Education, and Welfare and the Women's Bureau of the Department of Labor. The conference is planned to encourage development of day care services for children who need them; to examine the extent and variety of day care needs and resources; to identify roadblocks in providing day care services that are adequate in quantity, quality, and distri-

bution; to promote good standards for safeguarding the children served; to foster wider understanding of the pressing need for day care services; to stimulate broader community responsibility for providing day care services; and to develop recommendations for citizen and professional action at local, State, and national levels.

Representatives of voluntary and public social and health agencies, both national and international; citizens and professional organizations, labor and industry, and State departments concerned with welfare, labor, health, and education have been invited to attend.

Among the facts to be made available to the participants are the results of a survey made by the Women's Bureau and the Children's Bureau of the day care resources of the affiliates of national organizations, and the results of a questionnaire sent to State departments of public welfare by the Children's Bureau to secure information on licensed day care facilities.

A feature of the conference will be the premiere of a film on day care needs and services, produced for the Children's Bureau and the Pennsylvania State Department of Welfare by the Mental Health Film Board.

## *Juvenile Delinquency*

Proposals for achieving a diversified system of facilities for delinquent children in New York State were recently made by the Citizens' Committee on Children, a voluntary organization in New York City.

The committee's long range plans envisage the use of training schools solely for children for whom effective group programs can be designed and the development of other resources of various sizes, kinds, and specializations to care for children with other needs. These would include small, psychiatrically directed units as community-based residences for adolescents. The recommendations also include the strengthening of probation services and the development of aftercare programs to help the young person leaving an institution to adjust to his return to the community. According to the committee, the choice of facility for the child—including transfers—should be the responsibility of an administrative agency rather than of the committing judge.

Recognizing that full diversification can be developed only gradually, the committee suggests some immediate measures, among them: the establishment of institutions for rehabilitating children under 12, of facilities for severely disturbed delinquents, and of experimental work camps for 15- and 16-year-olds; experimentation with brief stays in institutions; the conversion of one large training school into an institution using peer group experience as its sole method of treatment; and the development of residence clubs as halfway houses between institutional life and community independence.

In its report, "When Children Must Be Committed," by Alfred J. Kahn, the committee stresses its intention to bring about better use of institutional care rather than to increase its use.

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A national workshop on training for probation services in juvenile courts was held at Milford, Mich., June 26–30, under the sponsorship of the Children's Bureau, the Council on Social Work Education, the National Council on Crime and Delinquency (formerly the National Probation and Parole Association), and Wayne State University School of Social Work. The workshop was financed by a grant from the Ford Foundation to Wayne State University.

Twenty-four participants from 18 States, drawn from juvenile courts, State departments of public welfare and State correctional agencies, and university graduate and undergraduate schools, met with an interdisciplinary group of workshop leaders and resource staff from the sponsoring agencies to consider the problems of training probation officers. The leaders included three social workers, a psychologist, a psychiatrist, and a sociologist.

The participants concentrated on two tasks: (1) an examination of the role of the probation officer in relation to the kinds of problems he experiences in working with individual delinquents and the knowledge, skills, and attitudes he needs to do his job; (2) a consideration of the most effective ways that professional education and inservice training programs might transmit this body of knowledge and skills to the large group of probation officers now practicing without professional training and to persons planning to enter the field.

The Children's Bureau will soon issue a publication based on the workshop and designed for the use of training personnel, administrators, and judges.

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The North Dakota Public Welfare Board's Division for Children and Youth has reported on a study of 102 cases of delinquency occurring during a 2½-month period in 15 predominantly rural counties in the State.

Initiated at the request of the North Dakota Judicial Council, the study was undertaken by the Division for Children and Youth in cooperation with the juvenile courts of four judicial districts. Technical aid was provided by the Children's Bureau, U.S. Department of Health, Education, and Welfare.

The information was obtained through interviews with each child and each of his parents or guardians, and from juvenile authorities, court officials, school representatives, social agencies, and other sources. Besides facts about the child's offense, the investigators collected data on any prior delinquency; his home and neighborhood; his interests, activities, and religious affiliation; his mental and physical health; his employment; the family income; relationships between the child and his parents; and results of psychological tests.

Among other facts, the report points out that 60 percent of the teenage offenders came from families with total incomes of less than $3,600; that in 50 percent of the offenders' families the mothers worked outside the home, most of them from economic necessity. Twenty-nine of the children had alcoholic fathers, five of them alcoholic mothers. Twenty-five of the children were living with one parent only.

The study also showed that although the majority of the young people (77 percent) had average intelligence or above (IQ 90–129), their school achievement was below average. About 40 percent had had to repeat one or two grades. School behavior problems had been considered serious for only 18 of the young people.

Information on parental attitudes in 68 of the families indicated that in 51 of them at least one parent took a negative attitude toward the young offender, and that in 22 families both parents regarded the young person negatively.

The study report, "Imperiled Youth," prepared by Mildred K. Hoadley and Olov G. Gardebring, contains a number of recommendations in regard to treat-

ment planning, community resources, law enforcement, and school programs. Among other steps these urge:

- That in each case of delinquency program planning be based on knowledge of the offender and his circumstances and provide for work with him, his parents, and his close associates.
- That law enforcement officials receive training in work with children and youth through special institutes and university courses.
- That there be close coordination between the work of these officials and juvenile courts.
- That training courses for court personnel be instituted.
- That adult education programs be developed concerning the growth processes of children generally and of those with special needs.
- That apprenticeships and "professional internships" be developed to give young people opportunity for various work experiences.
- That schools provide a greater differentiation in curriculum and more outlets for achievement.
- That social workers have an opportunity to add to their skills in working with problems arising from alcoholism.
- That socio-psychological evaluations and consultations be made available on a regional basis to county welfare workers, juvenile courts, and parents.

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The Maryland State Department of Public Welfare recently submitted a 10-year development program for the State's institutions for delinquent children to the State planning commission. The plan was drawn up at the direction of the 1957 State general assembly. At present the State's institutional resources include four training schools, three forestry camps, and a child study center for detaining, studying, and making recommendations as to final disposition of children awaiting court action.

On the basis of an expected 60 percent rise in the total 10–17 age group in the State in the next decade, the plan includes $5,400,000 worth of increases in facilities for institutional care for delinquents—additional cottages, new training schools and forestry camps, and expanded detention facilities, to add 589 beds to the present total of 1,000 available for care. According to the department's report, the expansion program is planned so that the new facilities could be used under the present system of racial segregation or in a nonsegregated system with diversified institutions "geared to the rehabilitation or reeducation of delinquent children based upon their treatment needs rather than on the present unsatisfactory bases of race or sex."

Other recommendations look toward reduction in the use of the training schools through the diversification of facilities and improvement of programs within and without institutions. They include: establishment of a residential treatment center for emotionally disturbed adolescents; an increase in probation services; use of clinical and other techniques in training schools to shorten the children's stay; more effective aftercare services for rehabilitation; reduction in the number of children housed in institution cottages at one time; provision of an institution for the youngest and least mature boys committed; experimentation in use of group training methods, like those used at Highfields Treatment Center, which is operated by the New Jersey Department of Institutions and Agencies.

## *Mental Retardation*

As an extension of the California program for the detection and treatment of phenylketonuria in children, the Children's Hospital in Los Angeles, with the help of the Children's Bureau and of the California State Department of Health, has developed a project aimed at assuring that all children under 3 having this condition receive treatment. The new project will supplement the case-finding program, involving 26 California counties and covering three-fourths of the population, by helping families who cannot afford the cost to secure the synthetic dietary product used in treatment.

Phenylketonuria, which results in mental retardation, is caused by a congenital inability of the baby's body to metabolize an amino acid called phenylalanine, and the treatment consists in keeping the child on a low-phenylalanine diet through the use of a synthetic food. According to present evidence, if mental retardation is to be prevented the disease must be recognized and treated early.

The objectives of the demonstration are: (1) To determine the extent of families' need for financial assistance in providing a low-phenylalanine diet in a State that carries on an active program to discover phenylketonuric children; (2) to determine the feasibility of supplying the synthetic product from one central place; (3) to obtain new information on the upper age limit at which low-phenylalanine diets are effective in preventing mental retardation.

## *Intercountry Adoptions*

A proposed draft convention on intercountry adoptions was prepared by the participants in an international seminar on intercountry adoptions in Leysin, Switzerland, May 22–31. The seminar was organized by the technical assistance office of the United Nations European Office and the Swiss Government, with the International Social Service and the International Union for Child Welfare serving as co-sponsors. Fifty-five persons from 15 countries participated.

The proposed convention, which sets down principles for the social and legal protection of children who leave their country for adoption elsewhere, will be presented for discussion to the Hague Conference on International Private Law in the Netherlands and then, with possible revisions as suggested by that body, to the United Nations Economic and Social Council. Adoption by the Council would mean presentation of the convention to the member countries of the United Nations for ratification.

Among the 11 principles stated in the proposed document, 6 are general principles about the conditions under which adoption is advisable for a child and 5 are specific principles regarding the safeguards necessary to protect the child when adoption is to be undertaken. The former, calling adoption "the best substitute for care by a child's own parents or close relatives," advocates greater attention to the possibilities of finding adoptive homes for children with handicaps; but they warn against too readily offering children for adoption, especially adoption in another country than their own.

The specific principles advocate preadoption study of the prospective adoptive home and of the child, attempts to "match" characteristics of child and adoptive parents, a trial period before adoption of the child in the prospective parents' home, and, in proxy and other inter-country adoptions, meticulousness

in following the legal requirements of both countries for making an adoption valid and in seeing that the legal responsibility for the child in the new country is established promptly.

The proposed convention will be included in a report of the seminar to be published before the end of 1960 by the United Nations Technical Assistance Office, Special European Program.

## *Childhood Accidents*

More than 50,000 accidental injuries to children under 15 were medically treated in two California counties in 1959, according to a child-injury survey made jointly by the California State Department of Public Health and the Alameda-Contra Costa [counties] Medical Association. The figure includes 26,000 injuries treated in hospital emergency units.

The survey showed that: a majority of the accidents occurred in and around the home; young children were mostly injured inside the house, school age children in such places as the yard and the driveway; more 2-year-olds were injured than children of any other age; at every age more boys than girls were injured; falls led all types of accidents among children of all ages; poisoning and ingestion of a foreign body were common among children under 3 years of age, with aspirin, especially "baby aspirin," the leading substance involved; injuries incurred in automobile accidents and burns were generally more severe than those from other types of accident and more frequently resulted in hospitalization.

The State department of public health is following up the survey by conducting research to provide information on the causes of accidents and on underlying factors in some children's being involved in more than a normal "share."

The 1959 survey was the third in a series of annual child-injury surveys.

## *Child Welfare*

Eight justices of the Superior Court of Maine recently agreed that social studies made in one county by the State of Maine Department of Health and Welfare in relation to the children of couples in divorce actions were important and useful to the court in assuring that plans for custody, care, and support of the children were soundly based.

Nearly 150 studies were made as part of an experimental project carried out by the department's bureau of social welfare between September 1958 and June 1959 to test the value of social studies to the courts and to the families. Initiated by the court, which already had statutory authority to ask for such service, and financed through Children's Bureau grant-in-aid funds for child welfare services, the project was conducted in Cumberland County, which includes Portland, the largest city in the State. Two caseworkers were assigned to the project by the department. The work was directed by an independent social welfare consultant firm, Laurin Hyde Associates.

The judges referred cases to the project that in their opinion required inquiry into the plans for the children's care. In some of these the parents were disputing questions of custody, care, support, or visiting arrangements. In some, evidence showed need of protective services for the children.

The project received referrals of 205 cases, about 70 percent of the number of divorce petitions filed during the 10-month period. The couples were informed by the judge that they did not need to accept the service unless they wished to. Analysis of 174 cases referred, which came to hearing between October and May, shows social studies were made in 146 cases. In only 18 cases did the persons involved fail to accept the offer of an interview with the caseworker.

In the family studies the project caseworkers interviewed husbands and wives, relatives, substitute parents, and older children. Younger children were visited at their homes to observe their relationships with the mother or substitute parent. Any new home proposed for placement of a child was also visited and studied.

After the caseworker completed her study of a family she submitted a written report to the judge, summarizing and evaluating plans for the children's care and making recommendations as to custody and amount of support. The report could not be seen by anyone else except with the judge's permission.

Before and after each of the 1-month court terms each of the caseworkers conferred with the presiding judge for that term about the families being studied. The caseworkers also conferred with the attorneys for the husband and wife to make clear the reasons for their recommendations. As a result no attorney found it necessary to cross-examine the workers in court. The county bar association appointed an ad hoc committee to observe and advise on the project.

In its report to the health and welfare department the consulting firm concluded that the favorable response of the bulk of the families in the project to the casework services offered shows the need for providing more casework services to persons in marital conflict. Pointing out that the judges involved in the project were in favor of extending throughout the State the plan for making social studies, the firm recommended that provisions for making such studies be set up within the department rather than within the court.

Copies of the report can be obtained from the Maine Department of Health and Welfare, Augusta, or the Laurin Hyde Associates, 164 West 79th Street, New York 24.

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In Kentucky a State department of child welfare, established by the 1960 legislature, began operating July 1, 1960. The new department is responsible for administration of all public child welfare services in the State, including operation of institutions for dependent and delinquent children; provision of protective services, foster family care, and adoption services; and licensing of children's institutions and agencies. The State program for aid to dependent children continues to be carried on by the State department of economic security, which was formerly responsible also for child welfare services.

## *About Youth*

Physical, social, and emotional needs of teenagers were discussed at a 3-day workshop held June 15–17 at Billings, Mont., under the sponsorship of the Eastern Montana College of Education and the Montana State Committee on Improving Family Life Education. Attending were representatives of a number of groups concerned with teenagers—judges, lawyers, child-welfare workers, physicians, nurses, health educators, nutritionists, clergymen, teachers, institution administrators, psychologists, marriage counselors, family life specialists, county extension agents, youth group leaders, and a number of teenagers themselves. Out-of-State speakers included a marriage counselor

from the Merrill-Palmer Institute of Human Development and Family Life, a physician from the Mental Health Research Institute, and a public health nurse from the Children's Bureau.

In a panel discussion six teenage boys and girls designated alcohol, cheating in school work, and "shotgun marriages" as the main problems of a high school environment. What they said made such an impression on the participants that the question of how to deal with these problems dominated the ensuing sessions, with the roles of sex education, preparation for parenthood, parental responsibility, and community responsibility coming in for considerable discussion.

At a postworkshop conference between the planning committee and the leaders the following recommendations were made: that a 3- or 4-day conference for teenagers be held, with the teenagers participating in the early planning; that a survey of the State be made to determine the availability of services offering counseling to teenagers on health problems, vocational choice, spiritual problems, and preparation for marriage; that steps be taken to provide such services where needed; and that communities be encouraged to strengthen health programs in the secondary schools.

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In an effort to understand the many problems related to growing up in America, the Children's Bureau, with the help of the Research Institute for the Study of Man, is planning a series of comparative anthropological studies of American youth to be carried out in various parts of the country. A pilot study is now getting underway in cooperation with the Social Science Institute and Department of Sociology and Anthropology of Washington University, St. Louis. The Ford Foundation has made two research fellowships available to the university for help in staffing the project.

Among the focal points for study are: young people's values, their models for imitation, their aspirations and expectations; the structure of peer-group life; codes and patterns of teenage behavior; relations between the young and their kin group; areas of conflict and agreement between youth and their parents; attitudes toward schools and legal authority; social maturation.

Selection of the subjects has been based on the following assumptions:

- That American industrial society in weakening the family structure, lengthening the period of "social adolescence," and shortening the work span of life, has separated the young (and the old) into subcultures.
- That many of the socializing functions once performed by parents, by other relatives, or by other adults known to the young have been largely taken over by the youthful peer group itself and by "people who have something to sell" to youngsters.
- That youth culture has become increasingly self-identifying and self-perpetuating, to the point of making many youngsters vacillate between feelings of pride and resentment in regard to their teenage status.
- That these developments are closely related to such conduct as delinquency and poor school performance by large numbers of potentially able young people.
- That youth culture is a functional part of the larger culture and can be fruitfully studied only in relation to it.

The research methods used will be primarily the participant-observer techniques that have been developed by social anthropology, supplemented by questionnaires and other instruments allowing for quantitative measurement.

## *Handicapped Children*

Nearly all the children in the Los Angeles area for whom the Child Amputee Prosthetics Project at the University of California at Los Angeles prescribes a substitute limb can now receive their initial training in using it in or near their own communities instead of spending 1 to 3 weeks at the project center. Nearly all of the children throughout the State who have been fitted by the project receive their continued training in or near their home communities.

This decentralization, which has been taking place gradually, has come about as a result of the workshops held by the project over a period of years to teach physical and occupational therapists from various parts of the State techniques for training children to use their prosthetic appliances. Because of the services now available in many localities, not only is the training more convenient for the children's families, but the project is able to accept more children for fitting and to free more of its staff time for developing new methods for meeting the patient's needs.

Children receiving training near their homes receive casework and psychiatric attention, if needed, from local services, and general medical care from family physicians or local clinics. The project medical staff maintains consistent communication with the local physicians concerned and continues to be responsible for physical problems related to the prosthesis.

The project is intensifying its workshop program for therapists so that more and more children can be trained in their own communities.

Among other recent advances in the project's work are: development of a method for the anatomical and functional classification of congenital amputations and deformities of the upper and lower extremities; and the use of visual aids for identifying and classifying amputations and prostheses in order to demonstrate sequences in child development as related to proficiency in the use of prostheses of various types. The project is also well along toward developing a test to evaluate the skills of children with amputations in operating their prostheses.

The Child Amputee Prosthetic Project, under the direction of the university's medical school, is sponsored by the bureau of crippled children's services, California State Department of Health, with Federal funds made available by the Children's Bureau. (See "Parents of Children With Congenital Amputation," by Wilma Gurney, CHILDREN, May–June 1958.) It has also received a grant from the National Institutes of Health for studies of prosthesis design and testing of experimental components in such appliances.

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About one-third of the Boy Scout units which replied to a questionnaire recently sent out by Boy Scouts of America reported having one or more members with handicaps—an average of two boys per unit. The handicaps include blindness, deafness, serious speech defects, paralysis from poliomyelitis, other types of crippling, cerebral palsy, mental retardation, and other conditions. The questionnaires were sent to a statistical sample including 4 percent of all registered Scout units in the country. Answers were received from 1,295 units—28 percent of the sample—including 35,551 boys.

# BOOK NOTES

REACHING THE FIGHTING GANG. New York City Youth Board. Foreword by Sheldon Glueck. Introduction by Ralph W. Whelan. New York City Youth Board, 79 Madison Avenue, New York 16. 1960. 305 pp. $3.

This history of the New York City Youth Board's street club project, called the Council of Social and Athletic Clubs, describes the makeup and activities of some of the city's antisocial teenage gangs and the methods used by the project's social workers to rechannel their energies into constructive directions. Excerpts from case records describe the ways a relationship is built up between the worker and the gang members, the role of supervision, and the worker's use of various skills, including casework, groupwork, and counseling and guidance techniques. Included is a statement of the board's policy of cooperation with law-enforcement and other community agencies, as well as personnel information for social workers interested in employment in the project.

MOTIVATION FOR CHILD PSYCHIATRY TREATMENT. Philip Lichtenberg, Robert Kohrman, Helen MacGregor. Preface by Roy R. Grinker. Russell & Russell, New York. 1960. 220 pp. $5.

Noting that families with a child needing psychological help vary greatly in their recognition of his need and that some fail to continue the child in treatment, the authors of this book—a clinical and social psychologist, a child psychiatrist and psychoanalyst, and a psychiatric social worker—present a report of an intensive study they made of 30 families, each with a child who had been accepted for treatment by a child psychiatry clinic.

The investigators studied such factors in the families' motivation for having their child treated as their beliefs about psychiatry, their early recognition of parent-child conflict, their feelings about the social consequences of the child's attending a psychiatric clinic, and the influence of friends, relatives, and school authorities on the families' action regarding attendance.

The authors express the opinion that further knowledge about the motivations of such families can be used to reduce the economic drain on clinics caused by missed appointments and by the family's failure to continue with treatment plans. Knowledge about the families that persevere is equally important to obtain, they say, for it can help the clinic in selecting the most appropriate type of therapy for the child.

MEDICAL CARE OF THE ADOLESCENT: a textbook concerning the medical care and understanding of adolescents themselves and of their disorders. J. Roswell Gallagher and staff physicians of the Adolescent Unit, Children's Hospital Center, Boston. Appleton-Century-Crofts, New York. 1960. 369 pp. $10.

Directed to all professions involved in the health care of boys and girls 12 to 21 years of age, this book tells about many of the illnesses, injuries, and personality difficulties experienced by young people during this period and offers detailed suggestions for dealing with them. The author points out a number of ways in which adolescents are different from children and from adults. He also notes a great range of difference within the adolescent years—for example, between the typical 13-year-old and the typical 18-year-old.

Among the subjects discussed, other than physical illnesses, are: growth and development, enuresis, fitness and fatigue, menstruation, athletic injuries, school failure, and emotional problems.

JUVENILE DELINQUENCY; its nature and control. Sophia M. Robison. Holt, Rinehart & Winston, New York. 1960. 546 pp. $6.75.

This textbook reviews the ideas of various disciplines concerning the causes of juvenile delinquency, and finds "inconclusive" explanations which have attempted to relate the phenomenon to family type, community conditions, and culture conflicts. The author observes, however, that the theories of the various professions are almost in agreement on one factor—the failure of parents of delinquent children to give assurances of continuing love and the moral discipline made acceptable by love.

The author, who is assistant director of the juvenile delinquency project of the city of New York, proposes five steps toward understanding and preventing delinquency: (1) To find out whether there is such an entity as "a delinquent" and whether behavior should be labeled delinquent regardless of the color, ethnic identification, or residence area of the person so labeled; (2) to define the appropriate role of each of the groups charged with responsibility in controlling delinquency, such as the police, the juvenile court, and the social-work profession; (3) to replace invalidated theories and treatment processes by implementing those for which the evidence appears most promising; (4) to reconsider our use of personnel and of physical plants; and (5) to establish effective methods of finding out the extent of delinquency and its areas of impact. The author recommends that communities set up central registers of delinquents and "that scientifically designed research projects replace the usual search for association of descriptive characteristics."

THE PROFESSIONAL HOUSEPARENT. Eva Burmeister. Columbia University Press, New York. 1960. 244 pp. $4.

Aimed at helping institutional houseparents in the care of children, this book discusses normal child development, the advantages and disadvantages of group living, the meaning of various types of routines to children and their management in an institution, discipline, ways of handling sex education, symptoms of emotional upset among children, and the basic attitudes which make a houseparent's job professional.

A case story of the progress made by a "tough teenage girl" in learning to trust people is used to illustrate the author's points.

The author is institutional consultant for the Federation of Protestant Welfare Agencies in New York City.

# IN THE JOURNALS

## *Maternal-Child Health*

A description of a course in "maternal-child health" nursing which combines instruction for students of maternal nursing and of pediatric nursing is described by Martha L. Adams and Mildred Disbrow in *Nursing Outlook*, July 1960. ("A Method of Teaching Maternal-Child Health Nursing.")

The course for both classes centers on the developments in one family, which is described by the authors. The classes discuss for example, the mother's pregnancy and how this is influenced by family problems, as well as how the pregnancy in turn influences such problems; also the father's influence on the family and its impact on him. Thus, the authors say, the students having obstetric experience do not lose sight of the family at home; those on the pediatric service keep in mind the effects of the birth process on mother and child.

Miss Adams is a graduate student in nursing research at the University of California at Los Angeles and Miss Disbrow is assistant professor of maternity nursing at the same university.

## *Narcotic Addicts*

Twelve percent of the 50,000 known narcotic addicts in the United States are under 21 years of age, according to official figures, writes Don Helbush in the Summer 1960 issue of the *California Youth Authority Quarterly*. ("A Report on Narcotics.") In a brief survey of the problem of drug addiction, the author, who is on the staff of the San Mateo (Calif.) Probation Department, quotes various authorities in contending that: (1) drug addiction has its beginnings in such conditions as unhappy homes, family tension, cultural conflict, lack of parental love, training, or control, and adolescent personality maladjustment; (2) the use of illicit drugs, like other evidences of delinquency and crime, is to be found chiefly among underprivileged groups; (3) fear of punishment has not proved effective in controlling addiction; (4) educational programs about the dangers of narcotics, though useful for parent-teacher and other adult groups, might be harmful if used where they would arouse undue curiosity, as among juveniles or other impressionable persons; and (5) the narcotic problem cannot be solved except by a variety of measures carried on simultaneously on many fronts.

## *Child Guidance*

A child guidance clinic should not rigidly exclude children known to be in some degree mentally defective or brain injured, even though the clinic's waiting list is long, says John A. Boston, Jr., M.D., in the June 1960 issue of the *American Journal of Public Health*. ("The Defective Child, His Family, and the Use of a Child Guidance Clinic.") The author, who is director of the Austin (Tex.) Community Guidance Center, maintains that many such children need child guidance services greatly and can benefit from them, and he describes his clinic's experience in working with children in the "intermediate or high-grade defective range."

Child guidance service, the author notes, is needed when the child's parents do not accept his mental disability as real; when they are unable to deal with the child successfully on account of such feelings as guilt or hostility; when a differential diagnosis of the child involves such conditions as childhood schizophrenia; or when the child has neurotic problems besides his organic defect.

## *Symposium on Child Welfare*

The *Social Service Review*, a quarterly, published in its June 1960 issue five papers on various aspects of child placement, under the heading, "Changing Needs and Practices in Child Welfare." Four of the papers were prepared by staff members, the fifth by a trustee, of the Illinois Children's Home and Aid Society in celebration of the society's 75th anniversary.

In the first paper, Ner Littner, psychiatrist, shows how disturbed feelings in an adult may reflect a disturbed child's difficulties. ("The Child's Need to Repeat His Past; some implications for placement.") Draza Kline, director of the society's foster care division, presents two papers: One suggests an approach to selecting foster homes for emotionally injured children ("Understanding and Evaluating a Foster Family's Capacity to Meet the Needs of an Individual Child"); the other examines ways of working with parents of children placed in foster care ("Service to Parents of Placed Children; some changing problems and goals"). In the fourth paper, Norman Herstein, assistant director of the foster care division, maintains that supervision in a placement agency is "indispensable." ("The Role of the Supervisor in a Placement Agency.")

The fifth paper ("Child Welfare Classics") by James Brown IV, a trustee of the society, reports on some items of child welfare literature published during the past 75 years selected by a committee of the staff as having enduring value.

## *Social Security Anniversary*

The *Social Security Bulletin* for August 1960 is a special issue commemorating the 25th anniversary of the passage of the Social Security Act. In it various articles review the quarter century's development in the programs carried on under the act, including old-age, survivors, and disability insurance; public assistance; maternal and child welfare; and unemployment insurance.

## *Medical Education*

Junior and senior medical students at the University of Vermont College of Medicine gain experience in comprehensive care of families through a program described by M. Alfred Haynes, M.D., in the *Journal of the American Medical Association* for July 23, 1960. ("An Approach to the Teaching of Family Care.") The author, who is director of the family care unit of the college of medicine's department of preventive medicine, points out that the objective of the program is not primarily to provide medical care to the families, although they receive the services without charge; but is to help students understand the influence of total environment on health.

As the article shows, each student enters the family care unit at the beginning of his third year. Along with a fourth-year student, who under supervision has primary responsibility for

the work, he is assigned to care for two families for 2 years, combining efforts for prevention, cure, and rehabilitation.

A team of full-time members of the department of preventive medicine—a physician, a public-health nurse, and a medical social worker—is responsible for teaching the students in the family care unit, and eight private physicians teach part time. Consultation is available, and the students learn to use community resources.

## *Delinquency Around the World*

Unrest among adolescents is leading to delinquent behavior in many parts of the world, but the patterns vary considerably, according to authorities interviewed by a representative of *World Health*, a bimonthly published by the World Health Organization. ("Who Are They?" May–June 1960.) In their discussion the psychiatrists, Dr. Eduardo E. Krapf, head of the Mental Health Section of WHO, and Dr. Trevor Gibbens, lecturer in forensic psychiatry at London University, point to variations and similarities in patterns of trouble caused by teenagers in different countries, and note a difference between actual delinquency and the riotous behavior that sometimes results when teenagers merely mill around aimlessly in large numbers.

In brief features accompanying the article, the head of WHO's health education section, Dr. John Burton, presents the theory that the appearance of the "teddy boy" phenomenon in England may be an expression of masculinity resulting from a changing ratio in the sexes; and Dr. Thorstein Guthe, chief of the WHO venereal disease section, discusses possible factors in the rising venereal disease rates among teenagers in Great Britain and the United States.

## *Choosing a Profession*

Factors influencing choice of dentistry as a career by more than 3,500 students entering dental training are presented in the *American Journal of Sociology* for July 1960. ("Some Motives for Entering Dentistry," by D. M. More and Nathan Kohn, Jr.) Through answers to a long questionnaire and through interviews with about a third of the students, the authors, who are managerial personnel consultants, found that the dental profession's chief attraction for the students was the independence it allows. What draws a young man into dentistry, the authors say, must be seen as a complex pattern of motives, but of five considered—prestige, financial earnings, human service, autonomy, and use of manual skill—the desire for autonomy is the most decisive.

## *The Mass Media*

The Child Study Association of America has devoted the major portion of the summer 1960 and final issue of its quarterly, *Child Study*, to papers and excerpts from the 1960 annual meeting of the association, which had the theme, "Mass media—their impact on children and family life in our culture." The chief medium discussed is television: its effect on little children and on adolescents; the responsibility of broadcasters and of parents for improving the programs; what research shows about the relation between behavior patterns and program content; the competition between television and the home and school; criteria for "good" and "bad" programs.

The issue also includes an article presenting the observations of a foreign visitor, Max Riske of New Zealand, on the recent White House Conference on Children and Youth.

According to an announcement in the issue, the journal is being discontinued as a result of a reorganization of the association's publication program.

# Guides and Reports

CHILDREN IN NEED OF PARENTS. Child Welfare League of America, 345 East 46th Street, New York 17. Publication F–27. 1960. 22 pp. 35 cents. Discounts on quantity orders.

A brief description of a study of more than 4,000 children in foster care in 9 communities, sponsored by the Child Welfare League of America. The study is fully reported in a 462-page book with the same title, by Henry S. Maas and Richard E. Engler, published by Columbia University Press, New York. (See CHILDREN, July–August 1960, pp. 155–157.)

ADOPTION OF ORIENTAL CHILDREN BY AMERICAN WHITE FAMILIES; an edited transcript of a symposium held under the auspices of International Social Service on May 1, 1959. Child Welfare League of America, 345 East 46th Street, New York 17. Publication A–24. 1960. 61 pp. $1.

Report of a panel discussion by social scientists and social workers on questions arising in the placement of Chinese children for adoption in Caucasian families. Besides social workers, the panel participants included a geneticist, a psychologist, a social psychiatrist and two anthropologists.

PRESENT PLEASURE. Nora Stirling. (One of a series: Plays for Living, a project of Family Service Association of America.) Discussion guide by Henrietta L. Gordon. Child Welfare League of America, 345 East 46th Street, New York 17. 1959. 32 pp. $2.

Shows what foster parents may experience while a troubled child is becoming adjusted to life in their home.

THE BLIND CHILD IN YOUR KINDERGARTEN. Polly Amrein. Paragon Publications, P.O. Box 867, South San Francisco, Calif. 1959. 18 pp. 75 cents.

Suggestions for helping blind children, addressed to kindergarten teachers or others who deal with young blind children.

PROMOTING MENTAL HEALTH. Norma Klein and Sara Lee Berkman. National Council of Jewish Women, 1 West 47th Street, New York 36. 1959. 31 pp., plus 8-page supplement.

A manual for members of sections of the council responsible for mental-health study groups and mental-health projects.

# READERS' EXCHANGE

BOGGS AND NORDFORS: *Prescription or practice?*

I have been asked whether the article in the July-August issue of CHILDREN describing Sweden's program for the mentally retarded indicates any "effect of cultural differences and differences in social values" between Sweden and the United States. ["Care of the Mentally Retarded in Sweden," by Elizabeth Boggs and Gösta Nordfors, CHILDREN, July–August 1960.]

One difference of emphasis does stand out between Sweden and either this country or Great Britain. Apparently, in Sweden if the parents do not agree with a plan for their retarded child, there is a much more formal process of adjudication and review than is *practically* possible in the English-speaking nations. The Swedes, at least in their legislation, seem to have taken more seriously than we have as yet the notion that the retarded, or at least their parents, are entitled to a day in court also. Of course, we have no way of knowing how such a hearing works out in practice; if we had figures on the number of times the Provincial central board for the mentally deficient rejects or seriously modifies the initial plan as a result of such a hearing, it would be illuminating.

In general, there is nothing in the article to show any difference in culture between Sweden and the United States—nor would one necessarily expect this result; they are both nations within Western European culture. One difficulty in judging whether there are any important differences in the treatment of the retarded in Sweden and the United States is that the article confines its statements to formal legislative doctrine and the theory of administrative procedure and fails to give data about how things actually work out in practice.

Anyone who studies the laws and regulations of our States can see that practice and prescription often vary; for instance, study of State legislation would suggest that sterilization must have rather an important part in our practice, but as a matter of fact most States disregard this; and, of course, speeches and reports about vocational rehabilitation often manage to exaggerate the actual habilitation or rehabilitation accomplished or even attempted. It is quite possible that Swedish practice differs as much from Swedish doctrine as ours does. Until we know how practice is carried on, we really cannot say much about the effect of culture on social values affecting the retarded and their management and care.

Even within the limits imposed by the fact that it is easy to summarize legislation and terribly difficult to learn what practice really is, there are aspects of this article which are puzzling. The article gives the impression that the annual statistical registration lists all mental defectives. Does it? Has it been checked for accuracy and comprehensiveness? Does it use IQ 60 or IQ 70 and if so, on the basis of what measurements, and if not, on the basis of what data as criteria of retardation? Unless we know facts like this, we really cannot tell what the differences are in cultural evaluation and social behavior as regards retardates.

*Lewis A. Dexter*
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*A planned program*

Though Swedish experts have no doubt debated among themselves the details of their new program for the retarded, to us its most striking feature is that it is comprehensively *planned*. Unfortunately, in the United States, in spite of its rich resources of knowledge and means, the effort of our multiple agencies, public and private, to cover the needs of mentally retarded children is both wasteful and inefficient. This seems less true of the programs in England, Holland, and the Soviet Union. We must insist on comprehensive governmental planning and support for the complex of services our handicapped children require.

In this country comprehensive planning would inevitably lead to solutions different from those of other lands, for we have our own traditions, needs, social organization, special resources, and governmental procedures to consider. Much of the experience of other countries, however, can be useful for us. Our country lacks almost completely the sheltered workshops and occupational centers found elsewhere. The system of guardianship in Sweden seems exemplary. Interesting too is the strong emphasis on special education for the retarded—characteristic of both the Swedish and Soviet arrangements—and the fact that the Swedish plan provides wisely for close liaison between the Royal Boards of Education and of Medicine.

In a number of our own States interdepartmental agencies have been created to prepare the way for coordinated efforts of separate governmental departments. I hope that in the near future this will be true on all governmental levels.

Since the principle of free and universal education has established itself solidly in our traditions, the extension of the principle to all children should not be difficult. The false limitation of educational opportunities to children designated as "educable" should be dropped.

In the areas of health care, welfare, and vocational placement some of our traditions continue to obstruct comprehensive planning, an obstruction that must be opposed by a simple recognition of necessity. It is time that the national voluntary organizations and certain of our public agencies give thought and leadership to the problem of comprehensive community planning for the needs of the retarded.

*Joseph Wortis, M.D.*
*Director of pediatric psychiatry, New York State University, Downstate Medical Center, Brooklyn, N.Y.*

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## SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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JUVENILE-COURT STATISTICS—1958. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 57. 1960. 18 pp. Single copies free.

Although in 1958 delinquency cases increased over the previous year's figure for the 10th consecutive year, says this report, the increase—7 percent—was much lower than that in previous years; it was only slightly higher than the rise in the child population (6 percent). The children involved in the delinquency cases, excluding traffic offenses, reported amounted to 405,000, or 1.7 percent of all the children aged 10–17 in the United States.

REPORT OF THE ADVISORY COUNCIL ON CHILD WELFARE SERVICES to the Department of Health, Education, and Welfare, Social Security Administration. 86th Congress, 2d Session, Senate. Document No. 92. 1960. 50 pp.

A report to Congress of an advisory council established at the direction of the 85th Congress to advise on effectuation of the provisions of part 3 of title V of the Social Security Act as amended in 1958. (See "A Look to the Future in Child Welfare Services," by John C. Kidneigh, CHILDREN, March–April 1960, pp. 66–70.) Supporting material about child welfare services is included.

MONGOLISM; hope through research. Department of Health, Education, and Welfare, Public Health Service. Prepared by the National Institute of Neurological Diseases and Blindness. PHS Publication No. 720, Health Information Series No. 94. 1960. 6 pp. 5 cents. $3 per 100 copies.

Briefly notes signs of Mongolism and possible causes, including 1959 discoveries suggesting a genetic origin; and points to current research on Mongolism and other brain disorders.

CRIPPLED CHILDREN'S PROGRAM; statistical highlights, 1958. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 56. 1960. 19 pp. Single copies free.

State crippled children's programs throughout the country served more than 325,000 children in 1958, an increase of 3.9 percent over the number served in the previous year, according to this report. The figure also represents a 50-percent increase over the number served in 1950. During the period 1950–58 the number of handicapped children under care in official programs rose from 3.9 per 1,000 children under 21 in the United States to 4.8 per 1,000.

HANDBOOK FOR RECREATION. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication, No. 231, revised 1959. 1960. 148 pp. 75 cents.

Mainly directed to volunteer recreation leaders, this handbook offers suggestions for planning and conducting programs for clubs, community groups, homes, schools, and churches. It also contains descriptions of numerous games, dances, and musical activities, hints about storytelling, and an index classifying activities according to occasion, space, group size, and age of participants. Written in cooperation with the National Recreation Association, it is a revision of a publication which has had many reprintings since it was first issued in 1937.

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# children

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NOVEMBER • DECEMBER 1960

# CHILD

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What Makes a Good Parent?

Trends in Infant Mortality

Mental Retardation in the USSR

Social Work in Medical Training

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SECURITY. This picture expresses the quality of parent-child relationship that we like to think is the birthright of every child. But actually parent-child relationships vary not only from family to family, but often even among parents and children within the same family. Some of the factors behind these variations have been under study at the Menninger Foundation and are discussed in the leading article in this issue.

With a research grant from the National Institute of Mental Health, psychologist Grace M. Heider is on leave from the Menninger Foundation, where for the past 10 years she has been studying normal children, and is working at the Psychological Institute at the University of Oslo, Norway. Dr. Heider is author, with Sibylle Escalona, of "Prediction and Outcome: A study in child development."

Before coming to the Children's Bureau 11 years ago, pediatrician Alice D. Chenoweth (left), was director of maternal and child health in the Kentucky State Department of Health. Dr. Eleanor P. Hunt, biostatician (right), has been with the Bureau for 15 years. Previously she worked on studies of growth and development and of nutrition in the Department of Agriculture and the Public Health Service.

A 1948 graduate of the New York School of Social Work, Columbia University, Roberta Peay has worked in the South Carolina State Board of Health as medical social worker in a regional rheumatic fever and crippled children's program, in the Richmond (Va.) Health Department, and in the social service department of the University of California Medical Center, San Francisco. She has been with the National Institute of Mental Health for the past 5 years.

Joseph Wortis worked in psychiatry at Bellevue Hospital in New York, at Johns Hopkins Hospital in Baltimore, and at hospitals abroad, in addition to his work at the Jewish Hospital in Brooklyn. Author of the book, "Soviet Psychiatry," published in 1950, he has a grant from the National Institute of Mental Health for the translation and interpretation of Russian psychiatric literature.

Before taking her present position, Lonis Liverman (left) was medical social work consultant in the Long Beach (Calif.) Department of Public Health. Nathalie Kennedy (right) was director of social service at Children's Hospital of the East Bay, Oakland, Calif. Their social work degrees came from the University of Southern California and Fordham University, respectively.

## ◀ *the authors*

*Some observations from a child development study inquiring into the question . . .*

# WHAT MAKES A GOOD PARENT?

GRACE M. HEIDER, Ph. D.

*Research Psychologist, The Coping Project, The Menninger Foundation, Topeka, Kans.*

A STUDY of child development raises the question, "What is a good parent—what kind of person provides a growth-fostering background for his child?" To ask this question is to be faced with the fact that there are no simple answers. In each case, what we are observing is not merely a parent but a parent as he affects a particular child. We are soon aware that we are dealing with a circular process: The way a parent affects a child is influenced by what the child does to the parent.

A cuddly baby may be highly gratifying to a mother who finds pleasure in a warm and nurturant relationship; a baby with sensitive skin who is uncomfortable in close physical contact may leave the same mother frustrated and impede her ability to offer the kinds of contact he would enjoy. Moreover, the impact of parent and child on each other may change as the child moves from the dependence of infancy into the motility of the preschool years.

This article will present some of the factors in parent-child relationships that have been taken into account in a recent study of child development and will show how the picture changes when the factors are applied to the same children at preschool and early school ages.[1]

The subjects of this study were 31 children who had been seen by research workers as infants and again at later ages in connection with two projects conducted in Topeka, Kans., during the last 13 years. The first of these projects, known as the infancy study, directed by Sibylle Escalona, Ph. D., and Mary Leitch, M.D.,[2] between 1947 and 1951, included 128 infants and their mothers. The second, known as the coping project, directed by Lois B. Murphy, Ph. D.,[3] was begun in 1952 and continued through the summer of 1960 with 31 of the children—27 mothers—who had taken part in the infancy study. Because each study included several pairs of siblings, there were fewer mothers than children. Both projects were carried on under the auspices of the Menninger Foundation and were largely supported by the National Institute of Mental Health, U.S. Department of Health, Education, and Welfare.

## *Relationships in Infancy*

In most of the families in the infancy study the mother had the direct responsibility for the child's care, the father having an effect on the child principally as his feelings and attitudes made it easier or harder for the mother to assume her role with the baby. The factors that have been used to judge the relationship of the mother to the baby fall under four headings: (1) those that refer primarily to what was observed and what the mother told about her interaction with the baby; (2) those that refer in a broader sense to the personal characteristics of the mother; (3) those that refer to the relationship between the parents; (4) those that refer to the mother's relationship with the larger family unit of grandparents and other relatives.

These factors cannot be regarded as an exhaustive list of what is important for the mother-baby rela-

tionship, but only as relevant points for making fairly clear-cut judgments of the material on the mother-child relationships that had been described. Nor can these factors be regarded as independent units that can be counted like so many coins to reach a sum. Rather, they should be viewed in relation to each other in a total picture of the attitudes of each mother and child toward each other, which can then be assessed within the group.

With one child a high or low rating on a particular item may decisively affect the whole balance; with another the same item may have relatively little influence. Just as the same quality in the environment, such as a noisy house, may be a source of considerable stress to a child who is especially sensitive to sound, a source of enjoyment to another child, and a matter of indifference to a third, so the same quality in the mother can affect different children in different ways, and the nature of the effect can only be known by an examination of the overall picture.

### 1. Items referring to the mother-child interaction

*Awareness of the baby's needs.* The mothers differed in the extent to which they seemed aware of the baby's momentary states and needs. Sheila's mother, for example, shifted the baby's position whenever she herself became restless, regardless of whether the baby might just have settled comfortably for a nap after a period of restlessness. Diane's mother, seemingly unaware of the fact that Diane was a child who enjoyed rather energetic bodily movement, constantly handled her in a way that restrained her limbs. Chester's mother, on the other hand, seemed to attune her own actions to those of the baby, just as one partner in a dance adapts his steps to those of another.

*Mother-child compatibility.* This term describes a basic physiological and temperamental compatibility between mother and infant. It refers to the extent to which a particular mother and a particular baby seem to meet each other's needs. The importance of this factor should modify a too-ready belief that there is a single, ideal style of mothering against which each case can be measured. It is, for instance, usually assumed that the mother who is sensitive to each nuance of the baby's behavior will handle her baby better than the mother who lacks this fine sensitivity. Yet among the babies we observed there were some in whom a certain kind of compatibility with their mothers seemed more important than sensitivity per se.

There was, for example, Lennie, whose mother, when he was 4 weeks old, showed a kind of "toughness" in handling him. Lennie was a sturdy, well-knit baby who fully satisfied his mother's desire for a boy, and she seemed to take pleasure in offering him a little less support than many mothers would have given a baby of that age. The two of them seemed to "understand" each other, and this understanding may have made for a sounder relationship than mere sensitivity.

On the other hand, Tommy, at 32 weeks, and his mother were less suited to each other. The mother was everything that our usual stereotype of the ideal mother includes—gentle, sensitive, and tender. But Tommy was an active, energetic baby who liked loud noises and apparently enjoyed the ordinary bumps that came his way. He seemed to demand rougher treatment than his mother gave naturally.

Lennie apparently was the kind of baby in whom his mother could find special pleasure and satisfaction, while Tommy's mother probably felt the need for a softer responsiveness than Tommy could give.

*Degree of respect for the baby's autonomy.* Some mothers appeared to understand the baby's moods and needs, and yet tried to make the baby do what they "knew" was best, for example, to go to sleep in a certain position or eat a certain amount. Other mothers used their awareness of the baby's individuality to let the baby take the lead. This difference was evident in the mother's attitudes toward their babies' schedules, toward toilet training, and toward food likes and dislikes, as well as in the way they handled their babies.

*Acceptance of the baby's own developmental plan.* Related to a tendency toward coercion in general was the attitude of the mother who had "read the book" or observed her neighbor's baby and who "knew" how fast her baby should be developing in each area. Other mothers were more relaxed about their babies.

*Degree of acceptance of the infant.* There were no mothers in the coping study who openly rejected their children and few among the 120 of the infancy study. Willingness to participate in such projects is in itself an indication of interest in the child and in that sense a selective factor. Nevertheless, differences existed in the degree of acceptance within the group. The way a mother held her baby, changes in

voice and expression as she approached him, and similar actions often gave clues to her feelings about her baby. Beyond this, the way mothers said what they said about their babies often conveyed more than their actual words.

A mother's feeling about the sex of her baby was sometimes a useful clue to her feeling about him. Gordon's petite, feminine mother expressed satisfaction with her very masculine baby, yet she treated him much as she would have treated the little girl for whom she had hoped. Lennie's mother, on the other hand, said that she and her husband had wanted a boy so much that they hardly dared admit it.

*The kind and amount of contact offered to the baby by the mother.* At home every mother necessarily spends some time away from her baby, the amounts of time varying with the mother and the circumstances. Differences between mothers in the amount of contact that they offered the baby during the 4-hour sessions in our study, when the baby was in a strange place and under observation by strangers, often seemed significant. For example, some mothers maintained constant physical contact, touching the baby when they were not actually holding him. Some kept their eyes on the baby or talked to him. Some, who did not keep up an actual contact in this way, remained in the part of the room where the baby was, obviously aware of him all of the time. Others went to the other end of the room and lost contact entirely during part of the session.

It seemed likely that most of the mothers who felt a need for constant physical contact with their infants as well as the ones who could separate themselves entirely from them were not altogether comfortable in their relationship with their babies.

*The mother's idea of what the baby should be.* Some mothers were able to sit back and watch the pattern that unfolded as the baby developed, offering support and guidance only where the baby seemed to need it. Other mothers tried to impose a pattern of their own on the child. Their success depended on a number of factors, including the strength of the mother's effort, the child's docility in the face of her pressures, and the consistency of mother's approach.

We find a variety of pictures among the cases in which the mother attempted to impose a pattern on the child. Ronnie and Greg both had mothers who wanted their babies to be "real boys," but even in infancy this pattern fitted Ronnie better than it fitted Greg. Gordon, since fate had made him a boy rather than the girl for whom his mother had hoped, had at least to be "cute" and "smart." Darlene had to be "good" to conform to the strict religious outlook of her family. Donald had to be both "good" and "smart" to meet the demands of a family that showed the stress of high upward mobility coupled with conservative religious leanings. Daryl, whose decorative mother had especially welcomed a little girl, had to be "pretty" and wear her clothes effectively, even at 28 weeks. The demands of Roddie's mother for a "real boy" who was also a model of deportment suggested confused values, common in our culture.

**2. Items referring specifically to the functioning of the mother.**

Another series of items used in judging the mother's relation to the child deals with the question, "What kind of person is this mother?"

*Level of adjustment.* The psychologists and psychiatrists on the basis of personal interviews made judgments about each mother's general stability. In several cases the mother was regarded as a person who might experience a psychotic break at some later time. In others the impression was of a robustly healthy personality. Most cases, of course, fell at some point between these extremes.

*The mother's feeling about her own competence in handling the baby.* This item told something about the mother's relationship with her baby, but still more about the way in which she appraised herself.

*Degree of acceptance of bodily functions in general.* Some mothers found it difficult to deal with the physical side of life in any area, while others were matter-of-fact about it. This factor was observed from the way a mother behaved when she had to change a soiled diaper, when she came within range of an unexpected spray of urine, or when she nursed her baby in a strange place. It was also inferred from what she said and did in less stressful situations.

*The mother's attitude toward breast feeding.* This item overlaps the previous one but includes greater detail about the mother's attitude toward breast feeding. It is concerned with the mother's decision as to breast feeding, the reasons she gave for arriving at this decision, and observations concerning her feelings in this connection. Some mothers expressed an almost euphoric enthusiasm about nursing their

babies, others a matter-of-fact, comfortable satisfaction, and still others embarrassment or repugnance. The mother who was serenely able to put her baby on a bottle when she did not want to nurse him was probably making her child more comfortable than the mother who reluctantly carried out her doctor's orders for breast feeding.

3. Items referring to the relationship between the parents.

Less information was obtained about fathers and the relationship between the parents than about the mother and the baby. Nevertheless, there were a few items for which clues to the parents' relationship were available in many cases.

*Temperamental compatibility of the parents.* In many cases something could be inferred about this from what the mother said—or did not say, as when she seemed to avoid speaking of her husband.

*Agreement in wishes about the baby's sex.* Close agreement or sharp disagreement among parents in their wishes for a boy or a girl often gave a clue to their relationship with one another. Gordon's father had wanted a boy as definitely as his wife had wanted a girl. The mothers of Molly and Susan had hoped for the boys their husbands wanted, although neither woman had strong personal preferences. Other mothers had shared their husbands' deep satisfaction that their first child was a son.

*Agreement on handling and disciplining the baby.* Since in most cases the methods of child care are regarded as the mother's province as long as the child is a baby, the failure of the father to play an active role did not seem significant. All the more notable, therefore, were exceptions, as in the family of Joanne whose mother reported that her husband disapproved of the way she managed the baby's schedule and felt that she was spoiling the child.

4. Items referring to the mother's relationship to a larger family unit.

This group of factors entered the picture only if members of a larger family unit lived in the vicinity of the baby's family. It included a number of items:

*The amount of help given by the family to the mother.* Chester's aunts and his grandmother were always at hand to be called on when difficulties arose. Ronnie's mother accepted help that was offered, but she would not have asked for it. Rachel's mother received help from her sister, but only in a major emergency. Janice's mother depended largely on her own resources and those of her husband.

*Attitude of the mother toward the larger family group.* Patsy's mother took for granted the considerable help given by her mother and sisters. Daryl's mother had help thrust upon her while Sally's mother had the task of giving eager grandparents on the two sides equal opportunity to participate in the life of the family. Teddy's mother made use of the services of essentially uncongenial and critical relatives-in-law, part of the time paying for them.

### *Preschool and Early School Ages*

In using this schedule with children who are somewhat beyond the age of infancy we find that many factors now affect the child directly which, at the earlier age, reached the child chiefly through their effect on the mother. The child past infancy understands a good deal of what goes on between his parents and how they feel about each other. The father, with his personality characteristics and behavior patterns; the siblings, with their relationships to parents and to each other; and other relatives, with their various roles, enter the picture in their own right. The child now lives in a world that includes possessions of his own, his home, neighborhood, and community. The role and status of his parents in this broader world begin to affect his relationship to his parents and theirs to him.

By this time too the child himself has become a person whose behavior extends further and reaches deeper than the infant's. He is at an age when new possibilities exist in addition to accepting, enjoying, ignoring, or rejecting another person, as a baby can. For example, he may begin to want something just because another person has it, not just for its own sake. More clearly differentiated feelings such as hostility, guilt, or a desire to protect begin to affect his relationships with other people. His life space now includes past and future as well as present. It includes what is absent as well as what is at hand, what is thought and imagined as well as what is objectively seen.

Beyond all these extensions in his psychological world and in his feelings, the child experiences changes in what he can do *in* and *to* environment. Our records show that even a 4-week-old child can do something toward shaping his environment for his own comfort. He can turn his head to avoid

food, or push at a blanket that comes up against his face, or squirm until he has made himself a more comfortable nest in his bassinet. The preschool child has become more mobile. He can move about, speak, and act in ways that go much further toward shaping his world.

### *Some Findings*

Many of the factors, such as the parent's acceptance of the child and satisfaction with what he was, seemed highly important to parent-child relationships. The parent's awareness of the child's needs and of what was going on with him was another such factor. Karen's mother, who by the time Karen was in school was busy with a family of seven children, gave a picture of Karen's world that contrasted sharply with the one Karen herself gave to the project's psychiatrist. Patsy's mother showed deep empathy with Patsy's moods, yet she often failed to recognize what was troubling the child. Molly's mother, on the other hand, seemed to know very well what lay back of changes in Molly's behavior.

In some cases, a parent seemed to understand a child's problems and yet be unable to accommodate his own attitudes in a way that would relieve the child. This was true of Darlene's parents who realized that their own religious and moral feelings created a gulf between their child and the community, and yet could do little to help her.

### *Pressures and Resistance*

The schedule used to evaluate family background included several items dealing with the mother's respect for the child's own individuality and bodily autonomy. Most of the children showed a certain degree of resistance to external pressures—some even in infancy and some not until later.

Diane, at 28 weeks, seemed to resent her mother's insensitive handling. By the time Diane was 4, her mother had become a more relaxed person. Observers then found Diane to be an easy, comfortable child, but they were not surprised that she was able to hold her own—for example, when an adult asked her questions that she did not choose to answer.

In contrast, Janice in infancy appeared to be a highly docile, plastic baby in the hands of a kind but rather coercive mother who "knew" exactly what her baby should do every moment and what should be offered to her. By the time Janice was 5, her mother's tension had increased. Resistance, which had been minimal at 28 weeks, had become a focus of the child's behavior, and mother-daughter conflict often reached uncomfortably high levels.

When Steve was a baby his mother seemed more interested in her own physical state than responsive to indications of the child's needs. When he was 5, she would pick him up and practically "pour" him into a snowsuit. Steve himself offered little resistance to such handling at either age, but he showed a high degree of motor tension as a baby and later.

Much of our data seems to justify the generalization that it is undesirable for a parent to impose a pattern on a child. Even when the pattern is congruent with the child's own direction of growth and the pressure is not severe, the imposition may impair the child's ability to handle his own life. When demands run counter to the child's natural pattern, they may restrict important areas of development. And they often contribute, as they seemed to with Janice, to a high degree of overt conflict, or as with Steve, to inner stress that affected both physical and psychological functioning.

Yet our data could not be interpreted unequivocally, even in regard to factors as evident as parental coercion. In the infancy study the mothers who were themselves systematic persons were sometimes happier and, therefore, better able to respond to their babies in general if the baby was on a schedule. A baby who had reached a crisis of fatigue in which he seemed unable to regain control was sometimes helped, for the moment at least, if his mother held him firmly in a position in which he was apt to fall asleep.

Obviously the way in which procedures were carried out was important. A mother could sometimes work out a schedule for her baby that involved a minimum of coercion; and a baby could sometimes be led by easy stages into falling asleep. But sometimes one saw fairly strong pressures exerted on a baby, and in individual cases it was not always clear whether or not this coercive treatment was undesirable.

The same generalization about the effects of parental pressures could be made in regard to the children at later ages, with the same questions holding even more significance. Greg's parents, for example, valued good grades and tidy homework—things that were relatively unimportant in Greg's creative, artistic approach to life. The parents were fairly successful in getting him to fall in with their pattern, and it was impossible to say how far, in the long run, this was going to be good or bad for this particular child.

It seemed unlikely that Greg's parents could

change their own basic outlook. They formed the major part of the child's setting and their approval was an important factor in his development. More than that, he lived in a world that would make demands very much like those they were making. A certain degree of compliance with the pressures that were exerted at home would make it easier for him to get on in this world. At the same time, he was being molded to an uncongenial pattern at a cost to other abilities that would have been satisfying to him and also might have produced a contribution to society. Greg, in this sense, poses a major question.

With another child, the parental pressure had different implications. Susan had suffered a severe attack of polio at the age of 3. Her own strong drive carried her a long way toward recovery, but unless her parents had enforced strong demands on her, her recovery would have been far less adequate than it was and she would have remained more seriously crippled than she did.

### *Compatibility*

The item on parent-child compatibility raised new issues as the child grew older. The effects of incompatibility were striking in the case of Vernon, a socially sensitive, complicated baby who did unusually well on infant tests. Vernon belonged in a sports-oriented family that had little regard for individual feelings and little interest in the intellectual side of life. At the age of 4, he had one of the highest IQ's in the group, yet at 8 he was doing only mediocre work in school. The fact that he was liked by his peers and successful in elementary school games suggested a good adjustment; but the meaning to him and to others of his failure to use his resources in other areas remains an unanswered question.

The factor of compatibility introduced a somewhat different complication with Martin. When he was 28 weeks old he and his gay, very verbal, and very charming mother made a delightful pair. The mother's sensitivity to her baby's changing moods did much to shelter him from what might otherwise have been the too-heavy impact of an ordinary environment. Yet, by the time Martin was 5, this very compatibility had intensified strains which he was finding hard to handle. He was competing with his somewhat more phlegmatic brother for his father's attention and at the same time suffering from guilt feelings toward the brother because of the easy victories that his own alertness and his mother's ready support brought him.

Tommy, at 32 weeks, had seemed to need more robust treatment than his gentle mother could offer him. As an older child he found his way into a strenuous little-boy life and an identification with his father that provided a pattern, both for his own very masculine interests and for a comfortable, flirtatious relationship with his mother. He apparently had reached this solution at considerable emotional and intellectual cost during his preschool years, but it seemed to have become established on a firm basis by the time he was in the fourth grade.

The results of this study are evidence of the importance of some factors affecting relationships between children and their parents. At the same time they show the difficulties involved in any attempt to designate a particular list of factors as good or bad as far as a particular child is concerned. Each factor must be considered in terms of the characteristics of both parent and child, and interactions between the child and his world must be taken into account in making any evaluation.

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[3] Murphy, Lois Barclay: Learning how children cope with problems. *Children*, July-August 1957.

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It takes youngsters a long time to grow up. Rather than attempt to make adults out of them, just be happy and content to make an adult out of yourself.

*Byron O. Hughes, Professor of Child Development, University of Michigan.*

# CURRENT TRENDS IN INFANT MORTALITY

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*Division of Health Services*

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AFTER TWO DECADES of declining rates, infant mortality in the United States rose from a record low of 26.0 deaths under 1 year per 1,000 live births in 1956 to 26.3 in 1957, to 27.1 in 1958.* Not since 1953–54 has a rate as high as 27.1 prevailed nationally. Provisional rates in 1959, and in the first 6 months of 1960, showed some decrease from the high levels of 1957 and 1958. Nevertheless, these rates—26.4 for 1959 and 25.9 for the first half of 1960—suggest that infant mortality is still elevated. They are considerably above levels to be expected on the basis of the generally downward trend in rate over the years 1950–57.

Reactions to this lack of progress in reducing infant mortality have varied from surprise to disbelief to a healthy skepticism regarding vital statistics. These have led us to examine available facts critically. In doing so we have become increasingly aware of the need for special State and local studies to follow up leads, not only from vital-records data, but from other community-wide sources of information as well.

During 1950–57 the annual reduction in rate on the average was 1.7 percent. Figure 1 projects the trend established in those years to 1958, 1959, and 1960.

The comparison of the recorded rate with the projected average level indicates that in 1958 the infant mortality rate was some 7 percent higher; in 1959, 6 percent higher; and in 1960 (January–June) about equally so. On a 12-month basis for 1960 an excess, perhaps not so large, is likely.

Thus a gap, though a narrower one, remains in 1958–60 between prevailing infant mortality levels and the lower levels which would be consistent with the 1950–57 trend. The excess in rate in 1958 meant a loss of 18 additional infants per 10,000 live births; and in 1959, a loss of 15.

The excesses of infant mortality in the past 3 years over projected levels were larger in the postneonatal period (1–11 months) than in the neonatal period (under 28 days). The provisional neonatal and postneonatal rates for 1960, shown in the table on page 217, are based on data for the first 5 months. Even when data are available for the 12 months of 1960, it seems likely that excess postneonatal mortality may be nearer 10 percent than the 23 percent shown in the table.

Neonatal mortality, on the basis of the same type of evidence, approximates in 1960 a level consistent with the trend during 1950–57. If confirmed by final figures for 1960 the elevation of neonatal mortality might be regarded as eliminated. The 1.1 percent decrease in rate annually between 1950 and 1957 represents the smallest relative reduction in rate in any period of comparable length since 1936.

*The source of birth and death data in this report is the National Office of Vital Statistics.

Widening differences in neonatal risks between white and nonwhite infants, and substantial differences among the several States, and between newborn in metropolitan and in other counties represent potentialities for reducing the neonatal death rate.

### *Impact on Infant Population*

In order to plan measures to promote more rapid reduction of infant mortality, identification of the groups of infants for whom risks are high is essential. Some clues are available from vital-records data of recent years.

Among infants less than a day old, reduction in mortality rate during 1950–57 was insignificant, though relatively large decreases in the rate were made from 1943 to 1950 (12.1 percent in toto) and from 1936 to 1943 (23.2 percent in toto). The mortality rate for nonwhite infants less than a day old increased during 1950–57 by 1.4 percent annually, the rise becoming evident as early as 1952.

The death rates for infants of 1 week to 3 months of age also dropped more slowly during 1950–57 than in previous periods. For infants of 1 to 3 weeks of age (7–27 days) the decrease in rate between 1950 and 1957 was 8 percent, as compared with 45 percent between 1943 and 1950; for those of 1 month to 3 months the drop was 10 percent between 1950 and 1957, but 41 percent from 1943 to 1950. In the latter age group, in 1958, the rate—4.2 deaths per 1,000 live births—was 14 percent higher than the rate to be expected from the trend for that age group during 1950-57, a 2 percent decrease in rate annually.

The nonwhite group showed much less improvement than the white group, although nonwhites had a higher mortality rate to begin with and so greater room for improvement. In fact, among nonwhite infants 1 week to 3 months of age no clearly defined trend of reduction during 1950–57 was evident.

During this period about 38 percent of infant deaths occurred on the first day of life, and nearly 1 in 4 at ages 1 week to 3 months. Thus about 3 out of 5 infant deaths occurred at the ages in which there had been marked slowing down of the decrease in infant mortality. The fact that in these early age groups, in which the large proportion of infant deaths occurred, the death rates have failed to decline at the same pace as previously has had a strong deterrent effect in the overall reduction of infant mortality.

Reduction in mortality of infants of all ages in metropolitan counties during 1950–57 has been half as rapid as among infants in nonmetropolitan counties, 1.3 percent decrease annually as compared with 2.7 percent. Nonwhite infants in metropolitan counties for whom the infant death rate was 66 percent higher than for white infants in 1950 and 92 percent higher in 1958 showed no decrease in mortality during 1950–57, the rate remaining in the neighborhood of 40 deaths per 1,000 live births. In the nonmetropolitan counties, mortality rates for nonwhite infants were even higher and showed only slight and doubtful improvement.

In 1958 State infant mortality rates ranged from a low of 21.3 per 1,000 live births in Rhode Island to 41.0 in Mississippi. Rhode Island also had the lowest neonatal mortality rate, 15.7, while the maximum rate of 30.2 was recorded for the District of Columbia. For the United States as a whole, infant mortality was 27.1 and neonatal mortality was 19.5.

State differences were wider in the case of mortality of infants 1–11 months of age. The lowest postneonatal rate, 4.9 per 1,000, was for Connecticut; the highest, 16.1 in Mississippi. Still higher rates were recorded for the Virgin Islands, 20.4, and Puerto Rico, 26.9.

### *Causes of Death*

The tabulated causes of deaths give some help in understanding recent trends in infant mortality, since they identify to some extent the morbidity groups with stationary or rising death rates.

About two-thirds of all infant deaths are from prenatal and natal causes, which include conditions such as immaturity, postnatal asphyxia and atelectasis (imperfect expansion of lung at birth), congenital malformations, birth injury, and certain other conditions, including hyaline membrane. Ninety percent of the deaths attributed to these cause categories occur in the first month of life; about two out of three of these are of prematurely born infants. Progress in decreasing the death rate for these causes has been much slower than for postnatal causes. Between the periods 1950–53 and 1954–57 the rate for prenatal and natal causes, 18.6 per 1,000 live births, was reduced only 4.3 percent, while for postnatal causes the reduction in rate was 10.3 percent—from 6.8 to 6.1. Among nonwhite infants the rate for prenatal and natal causes increased slightly, from 22.5 to 22.7.

While in general during 1950–57 decrease occurred in infant mortality from postnatal causes—such as certain infections and parasitic diseases, diseases of the digestive system, and accidents—death rates

from infections of unidentified types showed small but continuing increases. (See figure 2.) These included: pneumonia of the newborn, which increased in rate per 100,000 live births 5 percent between the periods 1950–1953 and 1954–1957, primarily in the nonwhite group; acute upper respiratory infection, bronchitis, and related infections, which increased 6 percent; meningitis, except meningococcal and tuberculous, 5 percent; "other infections of the newborn," 53 percent; and septicemia and pyemia, 48 percent. Jointly these infections during 1950–53 accounted for 5,159 deaths annually, or 137 per 100,000 live births. During 1954–57 the annual toll increased to 6,248 infant deaths, or 152 per 100,000 live births. Had the death rate for these causes decreased at about the pace of the death rate for infectious and parasitic diseases as a whole, the lives of approximately 2,500 infants annually in 1954–57 would have been spared.

### *Hypotheses for Study*

While we know something about the ages at which infants have been dying, the places where they have been dying, and the chief causes of death, we need to know much more before we can outline a control program. State and local studies are needed in which clinico-pathologic data, collected and evaluated by medical committees, and vital records data can be correlated with information about the mother's health, the family's level of living, and the medical services provided to the mother and infant.

Some of the questions needing answers are:

*To what extent is the rather stationary rate on the first day of life during the 1950's a result of more nearly complete birth and death registration, particularly of very small infants?*

*To what extent is the rising death rate of the first day for the nonwhite group related to an increase in incidence of prematurity?*

While prematurity among white infants decreased during the 1950's from 7.2 percent to 6.8 percent in 1958, it apparently increased in the nonwhite group from 10.4 percent in 1950 to 12.9 percent in 1958.

During 1950–58 nearly a million nonwhite persons left the South, going particularly to industrial and commercial centers in other geographic areas. In general this migration had the effect of increasing hospitalization for delivery, and perhaps of adding

**CURRENT EXCESS IN INFANT MORTALITY**

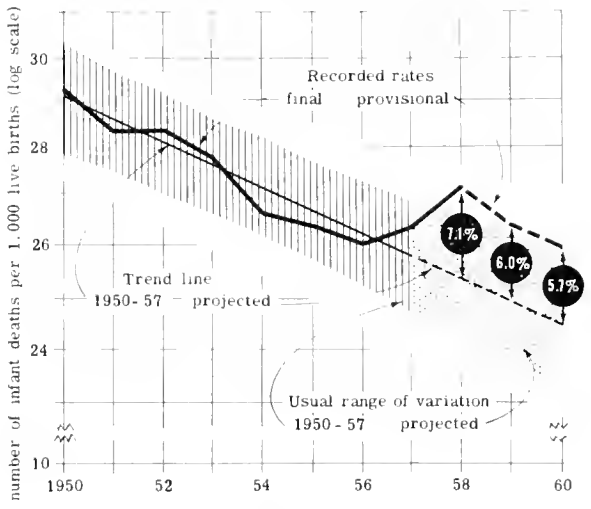


**Figure 1**

The recorded rates in this chart are based on registered live births and deaths. The trend line, estimated from the recorded rates during 1950–57, shows the annual decrease in rate, 1.7 percent. Rate values beyond the usual range of variations would probably occur less often than once in 20 trials.

to the completeness of registration of infant deaths and premature births, providing truer, though higher, estimates of mortality.

Data from the District of Columbia illustrate the effects in large cities of changes in population since 1950. Though the metropolitan area has grown by one-half million since 1950, the central city contributed only 5,000 to that increase. Though the proportion of white to nonwhite births changed little in the entire metropolitan area—about 3 percent increase in nonwhite births between 1950 and 1957—the picture was entirely different in the core city, where among residents, white births dropped from 56 percent to 35 percent and nonwhite births rose from 44 percent to 65 percent. In suburbia the percentage of white births rose from 90 percent to 92 percent; the nonwhite dropped from 10 percent to 8 percent.[1]

*What proportion of premature births and of infant deaths are associated with lack of prenatal care?*

Again the District of Columbia provides an example. In 1952, 30 percent of the births at the D.C. General Hospital, the public hospital, were without prenatal care; by 1956 the percentage without prenatal care had risen to 17 percent and it

remained at that level in 1957 and 1958. Of the women delivered at the D.C. General Hospital in 1956, the neonatal mortality for those without prenatal care was 41.6. (In the District as a whole in 1956 it was 23.9 for the total population; for the nonwhite population, 28.9.) In 1957, when 12.2 percent of the births at the hospital were premature, 24.5 percent of the mothers who had not had prenatal care gave birth to premature babies, as compared with 10.2 percent of the mothers who had had prenatal care.[1]

*What has been the effect on infant mortality of the one-third increase in number of infants born out of wedlock in the United States—from 141,600 in 1950 to 208,700 in 1958?*

*What part, if any, of the increased mortality from "other infections of the newborn", septicemia and pyemia, and several other categories of infection of undefined etiology, is associated with hospital-acquired staphylococcal disease?*

*What part, if any, did inadequacy of facilities and manpower for maternity care play in the infant mortality rates?*

This last question seems especially relevant since the great majority of births today take place in hospitals—98.2 percent of white births and 81.1 percent of nonwhite births in 1957.

Data from the American Hospital Association show that since 1946 the number of births has increased faster than the number of hospital bassinets.[2] Since bassinets and maternity beds can be presumed to be about equal in numbers, does this mean that in the Nation as a whole there is a shortage of maternity beds? Or, since hospital stay has been shortened in recent years, has the slower increase in beds been sufficient? Have hospital stays in maternity cases, perhaps, become too short?

Between 1946 and 1957 the stay for all patients in general hospitals decreased from an average of 9.1 to 7.6 days, reflecting recent scientific advances in medicine and more specific and more intensive therapy. For maternity patients the average length of stay in 1957 was even shorter—4.5 days. In some large public hospitals the stay for some patients was as short as 24 to 48 hours. In such instances the lag in growth of facilities, lack of personnel, and high cost have probably worked together to shorten the stay in the hospital.

Adequacy of maternity beds depends also not only on total number of beds but on their distribution. With the rapid changes of population in central cities the maternity wards of many public hospitals in large cities are reported to be overcrowded, while the maternity census in central city private hospitals is going down and in suburban hospitals is rising.

Medical manpower has not kept pace with increasing births. Though the number of physicians in private practice is increasing, the population growth has been even greater, so that the ratio of physicians to population has been declining. In spite of the increase in filled internships, the disparity between the number of available intern positions and the number of graduates of American medical schools has been growing steadily larger each year.[3]

"Physicians for a Growing America," the report

**INCREASES IN INFANT MORTALITY FROM INFECTIONS**

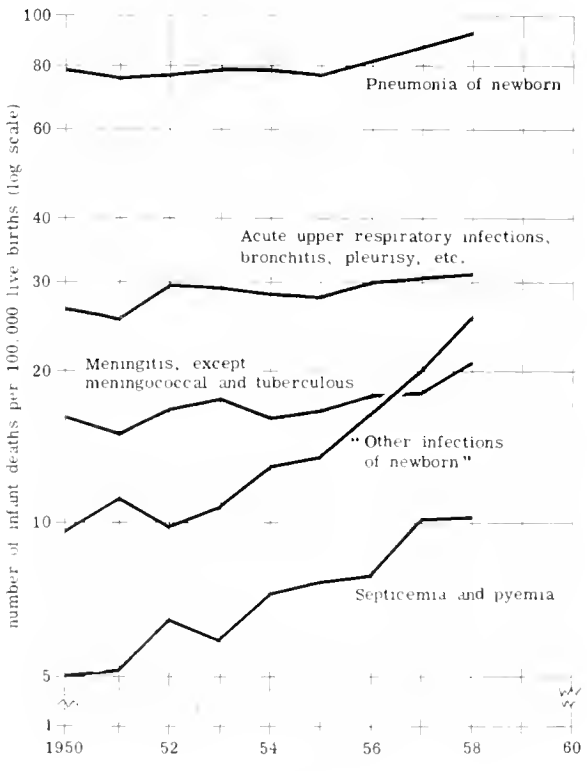


**Figure 2**

The causes shown here correspond to those of the International Statistical Classification of Diseases, Injuries, and Causes of Death. "Other infections of the newborn" are exclusive of pneumonia and diarrhea of the newborn.

## INFANT DEATHS PER 1,000 LIVE BIRTHS

### Neonatal

| | 1957 | 1958 | 1959 | 1960 (Jan.–May) |
|---|---|---|---|---|
| Percent excess of recorded over projected rate | +1.6% | +4.8% | +3.8% | +1.1% |
| *Recorded rate* | 19.1 | 19.5 | *19.1 | *18.4 |
| *Projected rate* assuming annual percentage reduction prevailing in 1950–57 (1.1%) | **18.8 | 18.6 | 18.4 | 18.2 |

### Postneonatal

| | | | | |
|---|---|---|---|---|
| Percent excess of recorded over projected rate | +2.9% | +11.8% | +10.6% | +23.4% |
| *Recorded rate* | 7.2 | 7.6 | *7.3 | *7.9 |
| *Projected rate* assuming annual percentage reduction prevailing in 1950–57 (3.3%) | **7.0 | 6.8 | 6.6 | 6.4 |

*Provisional.
**Estimate of the expected rate in 1957 pursuant to trend, 1950–57.

of a consultant group on medical education to the Surgeon General of the Public Health Service, calls the maintenance of the present ratio of physicians to population "a minimum essential to protect the health of the people of the United States," and states that to achieve this the number of physicians graduated annually by schools of medicine and osteopathy must be increased from the present 7,400 a year to some 11,000 by 1975.[5] In 1959 a total of 8,269 physicians were licensed to practice for the first time in the United States.[6]

What about nurses?

Though there was an 87 percent increase in the number of nurses employed by general hospitals between 1946 and 1959, the size of the increase is offset by the fact that in 1959 more than one-fifth of the professional nurses in general hospitals were part-time workers who were not likely to relieve the nursing shortage in some of the more critical personnel areas of the hospital such as the night shift in the nursery.[7]

The growth in the number of practical nurses and auxiliary workers in general hospitals has been more rapid than the increase in professional nurses. Whereas in 1946 the ratio of professional to nonprofessional nurses in general hospitals was about five to three, by 1959 the ratio was reversed in favor of the nonprofessional nursing staff to approximately one professional nurse to 1.1 practical nurse and auxiliary worker. One might seriously question whether quality of care has been affected by this change in the nursing staff of hospitals.

*Are community programs of services for mothers and infants adequate in coverage and in content?*

Between 1950 and 1957 services under maternal and child health programs in the United States have increased some. The proportion of mothers receiving medical-clinic services rose from 48 per 1,000 live births to 56 per 1,000; the proportion of mothers receiving public health nursing services increased from 71 per 1,000 births to 104 per 1,000; the proportion of infants receiving nursing services changed little, from 143 per 1,000 to 156. Infants attending well-child conferences were about 80 per 1,000 in 1950; 127 per 1,000 in 1957. Service rates have increased some since 1957, but not enought to fully offset the rise in infant mortality. Should the growth of these services be speeded up? Are they increasing where they are most needed? Are additional types of services needed?

Central cities face especially difficult problems in financing needed public services not only for health, but also for welfare, housing, and education—all areas relevant to the survival and health of infants. Migration of low-income families into, and of middle-income families out of cities, has resulted in greater need for public services within the cities and a reduced tax base to support them.

District of Columbia material is again illustrative. In a board of trade study in 1958 the median income for suburbia was $7,940; for the District, $5,660; for the area as a whole, $6,860. A study made by the Census Bureau for the District of Columbia in 1956 revealed 20.4 percent of families with income less than $3,000 a year—11.6 percent of the white families, 31 percent of the nonwhite; 46.8 percent with incomes below $5,000—30.8 percent of the white, 66.3 percent of the nonwhite.[1]

For the past several years, according to birth certificate reports, only 40 percent of births to resident mothers in the District of Columbia were attended by private physicians while 60 percent were hospital staff cases. Although the number of births to residents changed little between 1950 and 1958, the number occurring at the city hospital increased by some 23 percent. In 1958 more than 30 percent of these births occurred in the city hospital. These births represented 4 percent of the white births and about 47 percent of the nonwhite births in the District.

With a decreasing ability to tax and an increasing need for public services and with the ratio of physicians to population declining, cities face a serious problem in attacking the weak spots behind the mortality figures. This calls for more efficient use of medical and nursing manpower.

But no matter how skilled physicians, nurses, and other health workers are, they alone cannot speed the decline of infant mortality. Real progress will require the coordinated efforts of representatives of the fields of health, welfare, education, housing, and industry to improve conditions in families in which poor nutrition, poor housing, low levels of employment, and a large number of children combine to create a multiplicity of overwhelming problems.

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[1] Oppenheimer, Ella: Population changes and perinatal mortality. (Paper presented at American Public Health Association, October 1959, to be published.)

[2] Hospital statistics: non-Federal short-term general and other special hospitals (tables 1 and 9). *Hospitals*, August 1, 1958 (part 2).

[3] U.S. Department of Health, Education, and Welfare, Public Health Service: Health statistics from U.S. national health survey; hospitalization, patients discharged from short-stay hospitals, United States, July 1957–June 1958. Public Health Service Publication No. 584–B7 1959.

[4] American Medical Association, Chicago: Number of physicians classified as to type of practice (table 3). *In* the American Medical Directory, 20th ed., 1958.

[5] U.S. Department of Health, Education, and Welfare, Public Health Service: Physicians for a growing America; report of the Surgeon General's consultant group on medical education. Public Health Service Publication No. 709. 1959.

[6] Fifty-eighth annual presentation of licensure statistics by the Council on Medical Education and Hospitals of the American Medical Association: Activities of the Federation of State Medical Boards of the United States. *Journal of the American Medical Association*, May 28, 1960.

[7] Hospital statistics. *Hospitals*, August 1, 1960 (part 2).

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In a society that is increasingly influenced by science and technology, and in a world that has become so small that events in the most remote parts of it affect us all, it is becoming more and more difficult for the individual to find his niche, to create with his own hands and mind, to be a person in his own right.

Children do not grow automatically into civilized and mature human beings; nor does the answer to mature adulthood lie in favorable surroundings alone. Individuals do not become civilized and mature without the opportunity for thought and reflection; they do not become great until they are first creative.

A major question for us all in these days of rapid and extensive change, therefore, is how we can make it possible for young people to think in a culture where there is much to discourage thought; how we can provide the opportunity for reflection in a culture that regards action as one of the main criteria of success; how we can insure creativity in the spiritual sense in a society that places so much importance on material possessions.

*Leonard W. Mayo, Executive Director, Association for the Aid of Crippled Children, New York, to the 1960 White House Conference on Children and Youth.*

# MENTAL RETARDATION IN THE SOVIET UNION

JOSEPH WORTIS, M.D.

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DURING a recent 7-week visit to the Soviet Union under a grant from the National Institute of Mental Health, U.S. Department of Health, Education, and Welfare, I had an opportunity to visit eight cities and to make a number of observations and inquiries on various aspects of child care and psychiatric practice. Because of my special interest in mental retardation I gathered as much information on this subject as I could, and supplemented it with further study of the Russian literature. Although my visit coincided with the summer vacation period, so that I could not observe the schools, I was able to learn enough to describe briefly the main features of Soviet work in respect to retardation.

In the Soviet Union, mental retardation is viewed basically in the same way it is viewed here: as a problem involving both biological equipment and educational opportunity. Human intelligence—or the lack of it—is not regarded as a simple matter of genetic endowment, but as a complex phenomenon, implicating inborn peculiarities of nervous structure or function, diffuse or focal brain damage, sensory or motor defects, fatigability, educational development, psychological interest or incentive, capacity for attentiveness, distractibility, and a number of other related factors. There are, however, important differences in approach and emphasis among Soviet psychologists and educators as compared with those in this country.

In the Soviet Union a child's performance on a series of standardized tests, such as we employ in psychometric examination, is not regarded as a measure of intellectual capacity. Prof. A. R. Luria, whom I met at the Moscow Institute of Defectology last summer, said to me:

> An IQ of 65 might mean quite different things in four different children: the first might have a congenital brain defect; the second might be suffering from a general weakness of the nervous system due to fatigue, general debility, malnutrition or some other weakening condition correctable later in life; the third might have some motor or sensory defect, such as a partial hearing loss; and the fourth might be a perfectly normal child who lost a lot of time at school because of some protracted illness. An IQ is always a merely quantitative thing; it tells us little or nothing about the qualitative causes of the bad performance.

For these reasons psychometric testing is not used in the Soviet Union. It is not now the basis for diagnosis of mental deficiency nor for special educational placement.

For a period after the October revolution of 1917 western psychometrics enjoyed considerable vogue in the Soviet Union, and both backward and gifted children were sorted out by the psychometricians, called pedologists, for special educational placement. It was soon discovered, however, that the gifted child tended to come from the displaced upper classes, while a disproportionately large number of the backward children came from workers' and peasants' families, or from certain undeveloped national groups. Many complaints and criticisms and much theoretical discussion ensued, leading finally in 1936 to a resolution of the Communist party castigating the psychometricians for labeling an excessive number of normal children as defective, abolishing the whole profession of pedology, and inviting the pedologists to become teachers if they wished.

One consequence of this sweeping resolution was to give the educational system back to the teachers—called pedagogues in the Soviet Union—and to elevate pedagogy to a level of a serious and systematic science. To this day almost all psychological work is conducted in pedagogical institutes and its reports are published in pedagogical journals. The leading research institute on mental retardation, the Moscow Institute of Defectology, comes under the aegis of the Academy of Pedagogical Sciences,

Children in a work-therapy session at the Bekterev Institute, a school for the mentally retarded near Leningrad.

which is the planning and coordinating agency for scientific educational work.

The Institute of Defectology is staffed by about 50 scientific workers, of whom some 10 or 15 are psychologists, seven or eight neuropsychiatrists, while 20 or more could be described as scientific pedagogues, whose work differs very little from that of the psychologists. There are only one or two pediatricians on the staff. This research institute is associated with a small school, which is used for training and research purposes, but its own activities are limited to research on the development of diagnostic, analytic, and teaching techniques for the educationally handicapped, including the retarded. Its current budget is 10 million rubles a year, a very large sum, when one considers that the salary of a skilled scientific worker may be 30,000 to 60,000 rubles a year, and that of a laboratory assistant 7,000 to 15,000 rubles.

Many research projects are being carried out at the Institute. They include a series of studies designed to correct faults in attentiveness associated with asthenia or fatigability or faults in plasticity. These studies and others reveal a concern for correctable *physiological* malfunctions of the brain—in contrast to the common assumption in this country that brain dysfunction necessarily means anatomical defect. Professor Eugene Sokolov, an associate of Professor Luria at the University of Moscow, is doing remarkable work in the measuring and recording of attentiveness by studying a number of physiological variables, especially shifting changes in the caliber of the blood vessels of the scalp and fingers. By means of these methods it is now possible to record the response of children to words related by sounds or by meaning, and thus to study the steps through which language development proceeds in both normal and defective children. This has important implications for the analysis of the thinking processes and for corrective education. Professor Luria has for a long time been interested in the organizing role of speech in the development of thinking and of abstract concepts in children.

One result of research carried out at the Institute is the development of an ingenious pencil-shaped photoelectric scanning device that emits distinctive sounds when passed over printed letters, so that the blind can learn to read by ear.

### *Definition*

Soviet workers in the area of retardation tend to narrow the field to those types of retardation presumed to be due to cerebral defects or inadequacies, and to regard types of intellectual or educational backwardness due to social, educational, or psychological causes as problems of general pedagogy. The preferred term for mental deficiency is oligophrenia, which has connotations of a medical nature. Dr. Pevsner, the author of a recent textbook on oligophrenia and a member of the Institute's staff has described it as "a kind of underdevelopment of the complex forms of mental activity which arises as a result of an organic lesion of the central nervous system at different stages of the intrauterine development of the fetus, or in the very early period of the child's life."

The diagnosis of oligophrenia, Dr. Pevsner told me, should be limited to those children who can be presumed to have suffered an actual brain injury in intrauterine, perinatal, or early infant life. She said it was reasonable to assume that the main pathological lesion in such cases was a diffuse injury or defect of the cortex, though she acknowledged that certain other associated factors may be encountered, mainly of two kinds: She said that hydrocephalus seemed to be a common associated factor in mental deficiency and that a superimposed focal lesion may complicate a diffuse brain injury.

Dr. Pevsner also expressed the opinion that the crucial physiological factor in the pathogenesis of mental deficiency was the inertness or immobility of the feebleminded child's reactions. Acknowledging that the element of anatomical defect must be con-

sidered too, she said that this may well express itself by contributing to the physiological inertness or lack of plasticity, and hence to an incapacity to shift or modulate in the learning process. She pointed out that the mammalian brain, in its evolution, has constantly gained plasticity and that the lack of plasticity could be regarded as a lower evolutionary stage of brain development.

From a clinical point of view, a leading symptom among mental defectives is their lack of capacity for abstraction or conceptual generalization. Dr. Pevsner described three types in which the lack of plasticity could be encountered: (1) those having a weakened capacity for both excitation and inhibition; (2) those in which the inhibitory functions are weak—the restless or excited children; (3) those in which the excitatory processes are weak—the torbid, indolent children.

### *Special Education*

Children having these various types of defects are not segregated according to type or diagnosis but are mingled in special schools. The Soviet pedagogues regard it as undesirable to have a school group consisting only of children with one type of symptom—hyperactivity, for instance. The teachers are instructed in the specific difficulties of each child and are then expected to individualize their understanding and approach to the educational problem the child presents.

For example, the hyperactive child is first taught inhibition by external restraint. A teacher may actually hold a hand over the child's mouth or restrain his mobility. At a later stage the child may be expected to impose his external restraint upon himself by clapping his own hand over his mouth, and still later the restraint may become internalized, an important gain for the child.

The proportion of boarding schools among these special facilities is high: in the Russian Federated Republic, out of 301 special schools, 130 are boarding schools. In Leningrad, three out of eight special schools are boarding schools.

The more severely retarded children—imbeciles and idiots—are dealt with outside the school system, in special hospitals and day centers. These are under the control of the Ministry of Social Welfare. I do not know how many children are so placed.

J. Tizard,[1] a British visitor to the U.S.S.R. a few years ago reported that the education of defective school children includes solid groundwork in reading, writing, and arithmetic, and elementary instruction in the natural sciences, geography, history, civics, drawing, singing, and physical education. During the last 5 years of training increasing emphasis is placed on vocational training. Tizard also reported that over 90 percent of the young people who complete special schools become employed in ordinary work. Prof. Zurabashvili and his staff in Tiflis told me that graduates of special schools go to work in regular factories or on collective or State farms, where special and appropriate tasks can be assigned to them. I unfortunately have no information on the number who fail to meet the curriculum requirements of these special schools, but I suspect their number is small.

Because of the Soviet distrust of psychometrics, and their special concern about the possibility of social and psychological reasons for retardation, children are ordinarily not placed in special education facilities for the retarded until they have spent a year in a normal class. The decision to transfer the student from the public school to an auxiliary school can be made only by a special commission, and only after it has been established that the public school has taken all necessary measures over an extended period of time to improve the child's success, without obtaining positive results; and after child psychiatrists have also concluded that the cause of the child's inability to pursue the public school studies is a mental deficiency due to an organic brain defect or disease. If there is no special school in the child's region or city the child may be sent to a school elsewhere. The regulations require that each student shall be accorded an annual review of his status by the pedagogical soviet of the school to determine the possibilities of his return to a regular public school.

There are no waiting lists for any of the special educational facilities, and all are fully staffed. Tizard describes a typical day school for 230 educationally subnormal children (all high grade defectives except for 20 imbeciles) which as generously staffed with teachers, and in addition had a physician and two feldshers (physician's assistants) in attendance. He also described a residential institution for 60 trainable, physically healthy imbecile children, aged 8 to 17, which had a staff of 32; and another larger one near Leningrad with 240 children (75 high grade imbeciles, 80 low grade imbeciles, and 55 idiots, including 23 cot cases) and a staff of 107.

There is much medical activity with these children, a great deal of it preventive in nature—frequent examinations, massage, exercise, special diets—as well as conventional medical treatment.



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There is also some psychotherapy, speech therapy, and physiotherapy.

Teachers of the retarded get a special 5-year course of training in the defectology department of the teachers' training colleges. This is 1 to 2 years longer than the regular teacher training course. A regular teacher who wishes to work in this field must acquire additional training. Teachers of the retarded get 25 percent more than the regular teachers' salary of 800 to 1,100 rubles a month.

### *Incidence*

Though statistically reliable comparisons are not possible, and will not be for some time, there are indications that the actual amount of true mental deficiency in the Soviet Union is less than it is in the United States.

The strict policies on admission to special schools, Professor Luria told us, are partly responsible for the low percentage of children in special classes, a proportion he estimated roughly as less than one percent. After further inquiry and investigation I made an estimate which I believe to be more accurate. The result is even lower. In the Russian Federation Republic, which has a population of 113,000,000, there are 30,000 children in special classes for defectives, and an estimated additional 18,000 mentally retarded children still in the regular school, not yet diagnosed or placed, making a total of about 48,000 children regarded as suitable for special classes. Since a little more than 16,000,000 children are now attending the 10-year schools (corresponding to our primary and secondary schools), this would mean that one child out of every 350 children of school age, or less than one-third of one percent, is regarded as suitable for placement in the special classes for the retarded. These figures include children in special boarding schools.

Even if these rough estimates were doubled to make allowance for children outside the school system, the proportions would be considerably lower than the usual estimate of mental retardation in our population—3 percent. But it is, of course, not possible to get an accurate idea of prevalence from the numbers receiving services.

It is interesting to conjecture whether the apparent low rate of mental retardation in the Soviet Union may bear some relationship to the fact that the Soviet population is given free and comprehensive medical service—much of it preventive—from the womb to the grave. This attentive medical care, associated with liberal maternity leave policies and benefits (4 months leave with full pay, starting with the 8th month of pregnancy), may contribute to the health of offspring.

For example, the amount of prematurity (based on a birth weight of 2,500 g. or less) in the city of Kiev is reported as 4.9 per 100, compared with an overall rate of 9.4 per 100 reported in the city of New York in 1959, and over 16 per 100 for the Negro population in some districts of the city. The prematurity rates in Kiev and New York may, of course, be based on dissimilar reporting methods or varying completeness, but the differences are probably real.

The so-called psychoprophylactic or natural method of childbirth, which is used in 90 percent of the births in the Soviet Union, minimizes the use of drugs and may reduce the chance of brain damage.

The Cesarean-section rate is said to be generally around 2 percent in Soviet obstetrical services, and is reported as above 4 percent in many hospitals here. The many children we saw all over the Soviet Union impressed us as being unusually vigorous and robust.

### *Conclusions*

On the basis of my observations and studies, which were necessarily limited, I think I can fairly make the following general statements:

- The overall picture of mental retardation services and research in the Soviet Union compares favorably with our own, and is in some respects superior.
- The rejection of psychometric testing, the exclusion of social and psychological problems from the concept of oligophrenia, and—possibly—the comprehensive health services combine to reduce the incidence of diagnosed and recognized mental deficiency in the U.S.S.R. But valid statistical comparisons are difficult to achieve.
- Russian research in this field is more neurophysiological than is our own and tends to be more intimately related to educational practice.
- Vocational placement of the retarded adult seems to create no difficult problems in the Soviet Union.
- Special education is regarded as a branch of science. The teachers enjoy considerable social prestige.

Continued contacts between American and Soviet scientists and other professional persons, mutual interchange of information and personnel, and cooperative research undertakings promise to be mutually rewarding.

[1] Tizard, J.: Children in the U.S.S.R.; work on mental and physical handicaps. *Lancet*, December 20, 1958.

# THE EMOTIONAL PROBLEMS OF CHILDREN FACING HEART SURGERY

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IN THE PAST DECADE spectacular developments in heart surgery have resulted in the hospitalization of numerous children having congenital heart disease.[1] Experience with these children has shown that, as in other illnesses, the chances or speed of the child's habilitation can be affected not only by his general physical condition and the medical skills applied to it, but also by the illness' byproducts—its psycho-social aspects—and the understanding of these by persons in contact with the child or his parents.

Because the heart is such a vital organ—with life depending on its continuous functioning—to learn that a child has "heart trouble," with which he was *born*, is usually an extremely frightening experience for both child and parents. Moreover, while the new surgical techniques hold out hope for complete recovery for some, and partial recovery for others, they are not a panacea nor are they undertaken without risk. Their very newness may hold a special terror for many parents. Such fear can affect both the child's and the parents' ability to cooperate with doctors, nurses, social workers, and others on a hospital or clinic staff who are trying to help them. When the staff understands these feelings and other factors in the patient's or family's life that are entangled with their attitudes toward the child's condition, the psycho-social impediments to the child's recovery can be dealt with.

We see many of these children at the clinical center of the National Institutes of Health, the clinical research arm of the United States Public Health Service. The specific setting is the 26-bed nursing unit of the surgical branch of the National Heart Institute. The research interest of this branch includes both diagnostic and treatment aspects of congenital as well as other cardiac defects in children and in adults. About 50 percent of the patients in this unit are children under 16 years of age, most of whom are there for treatment of a congenital impairment of the heart.

These children are usually in the hospital for from 1 to 4 weeks. All have been referred for diagnosis or treatment by physicians, in private practice or connected with a clinic, hospital, or health and welfare agency. Coming from all over the United States and many foreign countries, they have different cultural and religious values and a variety of economic, educational, and social backgrounds. The only common factors among them when they arrive are that *they are being hospitalized*, *they are away from home*, and *they have a suspected heart lesion with which they were born*. These common factors, however, provide a springboard from which the hospital staff can take off in trying to communicate with new patients.

From this take-off we try to see farther into the personality and experience of each patient to find meanings which can help us make the hospital experience as constructive as possible for him. What have the symptoms of his condition—this heart murmur, this shortness of breath, this easy fatigability, these frequent upper respiratory infections, this blueness, or this lack of growth and development—meant to him and his family? What was the impact on his parents of learning that their child—perhaps their only child—had heart trouble at birth? How did they find this out? From a brusque statement which held out no hope for the child's life? From a calmly made explanation providing positive sugges-

tions for future care? Or from an offhand remark ending with "you have nothing to worry about, don't pay any attention to it?"

How did they react to the diagnosis? With a frantic search for opinions of other doctors, neighbors, or well-meaning friends, resulting in further confusion, desperation, and exhaustion of economic resources? By wrapping the child in an unhealthy, overprotective blanket, sacrificing all other members of the family to satisfy his every wish or whim? Did they find any helpful resources to turn to with their anxiety, their confusion, their fears, their guilt, their anger, their frustrations, their feelings of inadequacy, or their inability to understand and accept the diagnosis?

### *Parents and Children*

We have found that some parents have had as constructive an experience as possible in learning and facing the fact that their child had congenital heart disease. We have also found that many other parents, unfortunately, have had devastating experiences in this regard. We have seen the well-adjusted parent-child relationship. We have also seen dominating mothers, overprotective mothers and fathers, parents who are unable to deny the child anything; hostile parents who resent the hospital's rules, routines, or policies; neglecting and uninterested parents; confused and very frightened parents; and desperate parents. The difference in the parents' reactions has sometimes stemmed from the way they were handled when they were first told that *their* child had a congenital heart lesion. Therefore, we try to learn as much as we can about this from the referring source and from the parents.

We also find it important to know who these children and their parents are, where they come from, with whom and where they live. What are the parents' hopes and ambitions? How able are they to grasp the meaning of medical information? What are their other children like? What is their way of life? What does illness mean to them—stigma, weakness or inadequacy, will of God, punishment, superstition?

Very little psycho-social information about the parents or the child is made available to our staff prior to the child's admission to the hospital, and we find it impossible to "know" all of the patients and their parents during the short period of hospitalization. But it would help us greatly if doctors, nurses, welfare and health agencies, who have referred these patients to us and in many instances know them well, understood how important such knowledge can be to those who are trying to make the patient's hospital stay a constructive rather than a devastating experience.

We often find that the parents are more upset than the child, though, unfortunately, frequently both child and parents are upset. Children, particularly those under 4 or 5 years, generally reflect their parents' reactions, whether this be anxiety, panic, calmness, or assuredness.

Every child, of course, has a distinct personality. Thus, we find it important to know *him* or *her*—his way of life, his experiences at home, in school, at play. What are his likes and dislikes, his ambitions? What has his illness meant to him, what is his understanding of what is wrong with him and of why he has to come to the hospital? Does he feel he has done something wrong for which he is being punished, or does he regard it as another way of getting attention? We are continually made more and more aware of the need to listen to the child, and to let him tell us in his own way and words what his "heart trouble" means to him.

In our nursing unit the child is in a new and, most probably, frightening situation. It is not always easy for a strange person to communicate with a child immediately. If we knew something about him prior to his coming, we would find this a substantial bridge from his home to us and could use it to facilitate communication.

Some of our children have been hospitalized before, few or many times. Some have never been hospitalized before. In either case, a child and his accompanying parent should be prepared ahead of time for what to expect at the specific facility to which the child is going. Each medical center is different from others in many ways—its location, the kind of buildings and equipment it has, and places for parents to stay, visiting hours and other rules; the kinds of services and staff available; the character of the nearby community and the cost of places to stay; the accessibility to transportation. Some of our patients arrived at the nearby Naval Medical Center or Johns Hopkins Hospital in Baltimore. One family was actually headed for New York because the parents did not know the name of the medical center to which they had been referred.

### *Diagnostic Procedures*

Our patients for heart surgery or diagnosis are usually admitted on Sundays. The parents stay with the child throughout the admission process. They

accompany the child to the nursing unit and help with getting him settled in the two-bed room assigned to him. We try to see that he is with a compatible roommate, but unless we have some pertinent pre-admission data this effort must be based primarily on age, degree of illness, or type of care needed.

The reactions of the patients and their families to this first day of admission have been affected by the bigness and strangeness of the building; the new faces around them—admitting personnel, nurses, doctors, other new patients and their families—the anticipation of separation, and the actual separation when night comes.

We do not allow parents to stay in the hospital, and when some parents and patients come expecting to do so emotional and economic problems arise. The parents leave a frightened child (from whom they may have never been away at night) to go to a strange home, possibly by way of a strange and new transportation system, and usually at a greater cost than they had anticipated. While we have liberal and flexible visiting hours, they probably do not entirely offset the trauma to the young child of being separated from his parents at night.[2] The visiting hours for our unit are from 9 a.m. to 9 p.m., with permission for parents to come in early before certain procedures and surgery and to remain in the hospital overnight during the critical postsurgical period.

On the day following admission, all patients have routine X-rays, electrocardiograms, and blood tests. We try to prepare the patients and their families for these and, when indicated, we allow the parent to accompany the child during these procedures. While many children "know the ropes" generally because of former hospital experiences, each hospital has some differences in methods and procedures. If we know what the child's previous hospital experiences were we can anticipate areas of possible tension.

Other diagnostic procedures include cardiac catheterizations, angio-cardiograms, and aortograms. Not all tests are done on all children. Neither the children or their parents know this initially, but they soon observe what is going on with other patients. For some tests the children are put to sleep and for some they are not, depending on the age of the child, the nature of the test, and the reaction of the child during the study. Some tests take 2 hours, some 4 to 5 hours. All of these tests are fairly mild, but if the child and his parents are not helped to understand specifically what they can expect, they may suffer unnecessary anxiety based on fear of the unknown, fantasy, or misunderstanding.

Since each procedure might provide a clue as to whether the child has a heart lesion, whether further studies are indicated, whether surgery or anything at all can help the child, all procedures are potential sources of tension.

### *Handling Tension*

For many children, a simple explanation of where they are going and for what is enough to dispel the terror of the "unknown." For others, and for some parents, their apprehension is so out of proportion to the nature of the test that the services of the professional staff must be called upon to get at the root of the problem and help the child or his parent deal with it.

In our center, as at most hospitals, the medical and nursing staff see all of the patients. Therefore, they are in a position to note signs of tension, apprehension, or emotional upset. If they let the patient and his family know from the beginning that members of the staff recognize their fright, confusion, or disturbance and want to help them feel better, the parents and the patient usually can more freely express their concerns, and the days following admission become less frightening for them.

We have observed that *all* of our children and their parents come with some degree of apprehension. While some of this is dissipated after they have had a chance to have a look at the hospital, its staff, and the modus operandi, most parents show signs of tension throughout the period of their child's hospitalization. Some of them are able to handle this adequately on their own, some can do so with a little help from the social worker, physician, or nurse, but others need more intensive social casework help. Their emotional reactions to the experience are dependent not only on their personality structures and earlier experiences, but also on the nature of the study procedures to be undergone, the implications of the final diagnosis, the recommendations made, and the physical reactions to whatever surgery takes place.

In general, the children who are accompanied by parents seem less tense than their parents. Perhaps we do not know them as well as we know the parents, or perhaps they are less aware of the implications of what they are undergoing. The few children who have come without their parents have exhibited signs of extreme fear, tension, or anxiety.

Periods of waiting may be periods of heightened

anxiety for the child and his parents alike. Both child and parents may dread the tests—a state of mind which may be prolonged for the parents while they wait for the child to return to his room. Waiting to hear the results of tests may also increase anxiety. This is more apt to be true of parents than children, though we have also seen children whose anxiety during this period reached a point near panic or immobilization. Hospital staff busy preparing other patients for tests, surgery, or return home may fail to notice the extreme anxiety being suffered by some children and parents while they are waiting to hear the recommendations.

### *Reactions to Recommendations*

The most critical period emotionally for child and parents comes when they hear the surgeon's recommendations. These will take one of four directions:

1. No surgery is recommended because the suspected lesion either does not exist or is insignificant.

When this news is forthcoming, the anxious moment is usually replaced immediately by a sense of relief. In some instances, however, the reaction felt may be anger because of the child's past subjection to unnecessary tests and hospitalizations and to unnecessary limitations on normal childhood activities; because of the parents' emotional need to have a sick or dependent child; or because of the child's need to continue to receive the attention he has enjoyed.

2. Surgery offering low risk and a high chance of of cure.

Parents' reaction to this is usually one of relief and confidence in the surgeon's decision and skill. However, some parents are unable to express real questions about this decision when the child is asymptomatic and the risks involved in surgery even if described as minimal.

3. Surgery with significant risk for the child who has increasing and seriously disturbing symptoms.

A realistic response to this is fear for the life of the child. But parents differ greatly in their ability to understand the implications of this recommendation and the gravity of the choice they must make.

4. No surgery is available for the specific lesion or lesions in the child's heart.

A realistic response to this is loss of hope that the child will live to grow up. Crucial factors in the ability of the parents and child to face the inevitable are the way they have been informed of it and their abilities, emotional and intellectual, to understand the diagnosis and recommendations for care. The whole professional staff of the unit is responsible for seeing that the parents and the child get the help they need in asking questions, in expressing their feelings, in understanding the diagnosis, and in following recommendations for treatment.

There is enough of a realistic basis for fear when parents and child are confronted with approaching cardiac surgery or the grim prospects that an untreatable cardiac lesion presents without their having to contend with unrealistic ideas, concerns, or fantasies. Physician, nurse, medical social worker, chaplain, and a psychiatrist if indicated must all be available to patients and their families who are faced with these grave findings. No one professional discipline can provide adequate help alone.

### *The Surgical Period*

At our hospital some children for whom heart surgery is recommended are discharged to return for the operation at a later date; some remain to be operated upon within the next week or two. When the time approaches, the focus of all staff is on preparing the child for the operation. The surgeon, the nurse, the physical therapist, the anesthesiologist, the social worker, the chaplain are all involved. The other patients and their families also have an effect—sometimes good and sometimes bad—on the child's emotional condition during this presurgical period.

How far in advance the child is told the date of surgery depends on his age and emotional makeup. Although giving this information a long time ahead of the date sometimes seems to increase and prolong anxiety unnecessarily, it allows more time for helping the child to bring out his questions or express his fears. When both child and mother are extremely anxious, time is needed to help them both. If the staff is aware of the emotional condition of the child and his parents early in the hospital stay there is a better chance of preparing them psychologically for the more tense surgical period.

Children under 4 usually depend on their parents to take care of any situation, so if either the child's mother or father is with him throughout his hospital stay, *when* he is told about the date of the operation is not very important. What is important is the *way* his parents and the staff tell him about it and about what will happen then. If the child's parents are

not with him, the anticipation of surgery and the postsurgical period become much more frightening and the potentials for emotional and even physical trauma are greater.

For many of the operable patients and their parents the day of surgery and the 3 or 4 days afterward are, understandably, their most anxious days. The patient leaves the unit early in the morning and does not return until 2 to 6 hours later, depending on the type of operation. The parents remain in a solarium near the nursing unit while the operation takes place on another floor. The staff makes every effort to prepare the parents for the length of this waiting period, and for the fact that they cannot hear from the surgeon until this period is nearly over. The social worker is available to give the parents emotional support and has told the surgeons and nurses of any previous impressions she may have gained about their possible reactions to the strain. A chapel and Catholic, Jewish, and Protestant chaplains are also available to the parents.

After the patient returns to the unit the parents are allowed to see him in the postoperative room. They have been prepared to see the oxygen tent, the chest tubes, the attachments for intravenous infusions, and the like. For most parents the knowledge that the operation is over and that their child is back in the unit is a tremendous relief, although they have been told of the critical aspects of the immediate postsurgical period. Some parents are still overwhelmed by emotions at the first postoperative sight of their child.

For the child, the time in the postoperative room—usually about 3 days—where there are usually one to three other postsurgical patients is the most frightening period of all. He cannot understand his pain, his reactions from the anesthesia, the chest tubes, the need to cough. He shows his fright by his actions and in the expression in his eyes. During this time the child has a special nurse. Many children are unable to verbalize their fears and some of these patients physically cannot do so because of the nature of their operations, so adults, and especially the nurse, must try to understand the nature of their fears and to help them. They can explain the purpose of the frightening procedures and let the child know that these are the same for everyone, show him that Mommy and Daddy are at hand, agree that the pain hurts, tell him over and over—if reassurance is justified—that he is going to be all right. They can also try to keep his fright from becoming aggravated by what is happening to other people in the room. The patient does not know what is going to happen to him, and if another patient gets into trouble, undergoes other unpleasant procedures, or has to go back to the operating room, he has no way of knowing that these things are not in store for him. False reassurance, however, can be harmful, and only honest reassurance should be given.

We have known three children who in this postoperative period developed symptoms of gastric ulcer, which is closely associated with stress. All of them had previously shown signs of considerable tension but before the operation had been unable to express their fear. Careful evaluation of the degree and cause of the patient's tension and anxiety ought always to be made before surgery, and if this is extreme, surgery should be delayed if possible.

Children and parents alike tend to relax when the child leaves the postoperative room. Parents can give much more *verbal* expression to this feeling of relief than the children.

Most children are able to leave the hospital about 10 days or 2 weeks after their operation. Observations of the "cured" children on their followup visits indicate that the majority adjust well to having a normal heart, and little continued "cardiac neurosis" occurs.

If the surgery has been only a first step, the child and his parents are faced with the prospect of returning for more surgery at a later date when the child is older and larger. If we have been able to keep the emotional trauma of the first experience to a minimum, there is more hope that the patient and family will suffer less anxiety during the next operation.

If the surgery has not helped, that is, if the lesion is found on the operating table to be uncorrectable at that time or at all, the parents and child are faced with the loss of hope, or with the need to return for further and more serious surgery. This can mean renewed anxiety and apprehension, possible economic strain, renewed family separation and, sometimes, exhaustion of resources.

### *Causes of Tension*

The greatest support for a child during any part of the experience of hospitalization is that his parent or parents be with him.

In our unit one of the social worker's first responsibilities is to try to make it possible for at least one of the parents to bring the child to the hospital and to remain with him whenever hospital rules permit. Sometimes this has not been possible and

we have had children arrive at the hospital and remain without any visits from members of their family during the entire period. One was a foster child with no parents who cared. Some have come from places so distant—Alaska, even Iran—that the cost and time involved in travel have been too much for the parents. A few have been from families in which the mother had other children to care for while the father was away at work. In some instances community resources—union welfare funds, public welfare departments, crippled children's services—have helped the parents to get to the hospital for at least the critical pre- and post-surgical periods. When no parent arrives the unit tries to provide from its own staff a parent-like person to give the child special attention.

To the child, parents—even those who are not able to give their child a sufficient measure of love—mean safety and security, particularly during a stressful period. In our hospital we would much rather have a very anxious and disturbing parent turn up with a child than to have the child arrive alone. We would rather have both parents than one alone, as they can be a source of strength to each other.

We believe that much—though certainly not all—of the anxiety that children and their parents bring with them to the hospital might have been prevented:

**1.** If the person who had previously dealt with the family in relation to the child's illness had known more about the child's and the parents' background and their experience with illness and other crises, their intellectual and emotional makeup, their ability or inability to understand the meaning of the diagnosis, and other family problems—such as unemployment, social isolation, or marital discord—which might be aggravated by or projected onto the child's illness, and had shared this knowledge with the medical center staff.

**2.** If the person who had informed the family or child of the suspected heart condition had taken pains to dispel confusion and to avoid arousing unnecessary fright or over-optimism.

**3.** If the home community had had available the skills and facilities for the earlier treatment of certain defects and for helping the family to meet the cost of study and care, to understand what to expect in relation to the illness, to reach decisions about taking the child to the medical center, to make arrangements about getting there with due regard for other members of the family, and to deal with peripheral but aggravating and pressing family problems.

**4.** If the child had received some help in understanding his illness, and in clearing up his own fantasies, fears, and expectations about it, such as regarding it as a punishment for some undefined transgression, being in constant fear of dropping dead, or expecting constant attention.

**5.** If the child (or his parents) had not already had an unhappy hospital experience.

**6.** If the child's fears of a complete unknown (and those of his parents) had been allayed by careful briefing on what to expect at the medical center.

The community, of necessity, bears the brunt of responsibility for the provision of services to help solve the various kinds of problems worrying the family and the child. The hospital, even though separated by considerable distance from the home community, has equal responsibility for maintaining a constructive continuity of communication in relation to the patient's care and for letting the responsible persons in the community know about the kinds of problems these patients and their families are apt to face and the preparation they will need for the hospital experience. And while the child is hospitalized the hospital must, through the combined efforts of its medical, surgical, nursing, and social service, do everything possible to see that day to day experiences do not arouse unnecessary anxieties in the patient or his parents, and that help is forthcoming for dealing with those anxieties that are unavoidable.

These are not insurmountable problems, and we may feel more hopeful in trying to solve them if we compare the promises of cardiac surgery today with those in 1883 when a surgeon named Billroth said, "Let no man who hopes to retain the respect of his medical brethren dare to operate on the human heart."[3]

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*A course in family medicine in a medical school provides for . . .*

# SOCIAL WORK PARTICIPATION IN MEDICAL TRAINING

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SOCIAL WORK participation in medical education, although not a recent innovation, has gained considerable momentum in the past 15 years. During this period medical education has undergone extensive reevaluation by the medical profession.

This reevaluation, in which prominent social work leaders have been asked to participate, has led to the recommendations, among others, that medical knowledge should include knowledge of the social and emotional forces which affect patient care [1, 2] and that this should be recognized in medical school curricula through "the use of the medical social service staff on a faculty basis, as a specialized department capable of supplying instruction in the principles and practices of applied sociology." [3]

As changes in the curricula of several medical schools have taken place and as new schools have been established, the number of social workers added to medical school faculties has increased.

In 1946 the California Legislature appropriated funds for the construction of a new medical school at the University of California at Los Angeles. In planning the curriculum it was possible to incorporate some of the findings of the reevaluation studies of medical education and to include content regarding the social and emotional forces which affect medical care. Therefore, a family medicine course was designed. From the inception of the course in 1951, when the first class of medical students was admitted, social work instructors have been associated with it.

The family medicine course has been described as a "course in the problems of communication and human relations" [4, 5] as these are related to the practice of medicine. It is designed to complement the general medical curriculum and has three functions:

1. To bring to the attention of students the importance of sociological factors in the care of patients through observation and study of the structure of the family and the various forces reacting within and upon it.

2. To help students deepen their understanding of the meaning of human development in our society as it relates to medical care. (The term development, as used here, encompasses physical, neurological, mental, personality, and social development.)

3. To provide first and second year medical students with an opportunity to deal directly with patients, sustaining their interest in patient care until they have daily patient contact in the third and fourth years of medical school.

Some changes have been made in the details of the course since its beginning in 1951, but basically it remains the same.[4, 5] The general procedure is as follows: Early in his first year in medical school

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each student is assigned a family in a special teaching well-baby clinic in a city or county district health office. The student follows this family throughout his 4 years in medical school by periodic visits to the clinic and by home visits. In the first year the student comes for these clinic appointments once a month and makes a minimum of three home visits during the year. Once a month the entire class convenes for a case conference on interesting and medically important family situations or child development problems.

In the second year the student has three well-baby clinic appointments with his assigned family, scheduled at 3-month intervals. These follow the same general pattern as the first-year appointments. He also makes at least two home visits. In addition, he visits the University Nursery and Elementary School once a month during the first semester. He observes preschool and school age children in the classroom and on the playground and studies the nursery school program and the elementary school curriculum from the standpoint of child growth and development. These observations provide a continuum in the student's learning about child development from infancy in the well-baby clinic through childhood in the school. They also give medical students an opportunity to consider the impact of the elementary school on the development of the individual and the value of this knowledge to the physician in practice. Each month, preparatory to the observations, the entire class attends a lecture, followed by a discussion.

In the second semester of the second year, the family medicine course and the course on introduction to clinical medicine are integrated and each student is assigned another family to follow in addition to the family assigned him the first year. This second family is selected from patients registered in one of the clinics of the university medical center. The student is introduced to the patient in connection with his studies in physical diagnosis at which time he takes a complete medical and social history and does a thorough physical examination. He makes a home visit to amplify his information about the patient's total social situation and sees the patient again in the clinic as indicated.

In the third year the student sees his first-year family once in the well-baby clinic and is encouraged to follow the family through home visits and telephone calls. No clinic visits are scheduled in the fourth year but many students continue to maintain contact with the families.

An attempt is made in the third and fourth years to help students extend the concepts developed in the first 2 years to the daily care of their patients in the clinics and on the wards. In the third year, while students are assigned to pediatrics, they meet once a week with the pediatric and social work instructors in the course and the social worker in the pediatric clinic to discuss the social aspects of patient care both in a general way and in relation to the specific patients they are seeing. A similar program continues in the fourth year. In addition, all of the social workers of the university hospital are involved in the family medicine course. They work closely with students on the problems of any of the patients assigned to the students in the course that may be under care in the university medical center, and they are also available for consultation regarding other patients.

### *Social Work Participation*

Present at each teaching well-baby clinic session in the program for first-year students are the clinician (a pediatrician), the social worker, and the public health nurse, as well as the students. The clinicians and the social workers in these special clinics are members of the medical school faculty. The public health nurses are provided by the city and county health departments. Families for student assignment are selected by the public health nurses from the clientele of the regular well-baby clinics. Criteria for selection include: the presence of an infant under 6 months of age; intent on the part of the family to remain in the community for at least 4 years; and willingness on the part of the family to participate in the program. Families with overwhelming medical or social pathology are excluded.

No more than six or seven students and families are scheduled for each clinic session. All of the students attending on a given afternoon are present when the clinician examines each baby and interviews the mother or both parents. Before each family and child are seen, their student presents the social history information he has secured about them to the clinic staff and to the other students. The clinician makes use of this information in his discussion with the family, pursuing some of the mother's questions in greater detail and adjusting his comments and recommendations to her social and cultural needs. Thus, the students can see that the histories they have obtained are significant and functional in the rendering of care in the well-baby clinic.

Following the clinic appointments, the students have an opportunity to discuss what they have observed with the staff. These postclinic discussions consider parent-child relationships, sibling relationships, implications of pathology or abnormality noted during the physical examination of the child, eating and sleeping patterns of children, toilet training, discipline, and other matters related to the normal growth and development of children. They also deal with the influence of the parents' own families and cultural backgrounds on child rearing practices, on attitudes toward health and medical care, and on the relationship of the families to the community, including social, school, and religious ties.

At the monthly case conferences, except at the first two sessions which are devoted to lectures, the students make the case presentations and discuss them with help from the instructors and occasional invited guests. The cases are selected to illustrate general concepts that emphasize the major objectives of the course. The first-year students' presentations during a recent academic year included: *December*, communication with a talkative mother and with a quiet mother, presented by two students; *January*, cultural adaptations of a Mexican-American family; *February*, a family with an adopted child, discussed after presentation by a professor of law; *March*, a mother with diabetes and healed tuberculosis; *April*, a mother with a psychiatric problem and hypertension, discussed after presentation by a professor of psychiatry; *May*, a family with a large hospital bill and other medical expenses, discussed after presentation by a hospital administrator. The three monthly sessions which preceded these presentations were devoted to an orientation lecture, a lecture by a sociologist on the family in our society, and a presentation by a fourth-year student of his experience with the family assigned to him in his first year.

Each student is required to submit a report of his observations of his family at the end of the first semester and a supplementary report at the end of the year. By the end of the first year, students are expected to have learned some of the pertinent social history of the family in each of the following categories:

1. Family constellation: name, age, and sex of each member of immediate family and other members of the household; how long married; and length of time in the community.

2. Family cultural background: race, nationality, ethnic and cultural traditions, religion, parental family backgrounds, and educational level of family members.

3. Family characteristics: housing, neighborhood, employment of family members, family mobility, and health of family members.

4. Current family social situation: intellectual interests, hobbies, and other activities; family unity or diversity of interests, and family attitudes toward health and medical care.

5. Family relationship with the community: school attendance, church affiliation, club and civic activities.

## *Social Work Teaching*

The goal of social work teaching in the family medicine course is essentially the same as in other social work participation in medical education—to transmit some of the broad principles and concepts of professional social work knowledge that can be useful to physicians in the practice of medicine. These include: acceptance of the individual's right to self-determination within the limits imposed by the situation in which he finds himself and the limits set by society; respect for the dignity of the person; understanding of the need for a family-oriented approach to medical and psychiatric problems and for a careful social exploration of each case; and awareness of the impact of the medical problem on the patient and the family and of the need to identify the strengths in a situation that can be enlisted in the patient's behalf.

Because these concepts and principles are not the exclusive province of social work, responsibility for transmitting them is shared with other professional disciplines on the medical school faculty. The social work teacher, however, also helps the medical student to attain knowledge of the function of social work and to develop skill in using social work services effectively for his patients.

In the first-year program of the family medicine course social work teaching goals are appropriately limited. Since this course is planned to involve all 4 years in medical school, the full goal is not expected to be achieved in any one year. The objective in the first year is to help the student enhance his understanding of the family assigned him and to develop skill in communicating with its members. During this year, the social work instructor tries to help the student to sharpen his awareness of the stresses affecting his assigned family and its relationship to the community and to become more cognizant of the significance of its environment and cultural background, which may be different from his own.

In working toward attainment of these first-year goals the social work instructor functions in the well-baby clinics as an observer of students and families and of the interaction between them, as a specialist

with responsibility for teaching specific content, and as an aid in promoting group rapport. In addition, she carries on interviews with students to help them extend and consolidate the knowledge gained in the clinics and participates with other staff members of the course in the on-going evaluation of students' progress.

What the social work instructor observes is determined by the kaleidoscopic character of the clinic sessions. While the clinician is simultaneously examining an infant, counseling the mother or both parents, and teaching the students, the social work instructor is in a strategic position to observe the dynamics of personal reactions and relationships. Depending upon the situation, these observations encompass the students' comfort or discomfort in his student-observer role; the reactions of the students to the examination of the infant; the parent-child relationship; the clinician's counseling and the mother's response to it; and the students' comprehension of the clinician's instruction.

On the basis of these observations, the social work instructor advises the students at appropriate points during the clinic sessions about certain areas on which to focus attention. For instance, a mother who usually communicates poorly may, in response to the skillful interviewing of the clinician, be furnishing significant information about her baby. At this stage in the students' learning, the clinician's interviewing techniques may be too subtle for the students to grasp unless specifically pointed out to them. While this is being done, the instructor can stress the importance for present and future care of the information the clinician is seeking. If more amplification is indicated, the social work instructor brings the incident to the clinician's attention in the informal discussion period.

At other times the students may ask the social work instructor about the validity of some observation they have made regarding a single family or a group of families seen during the afternoon. For example, after observing a young mother with her first-born child, they may want to know whether she seems unusually anxious or whether all young, inexperienced mothers act as though they are afraid of handling their babies.

The students are encouraged to describe what they have observed about the mother and child which created the impression they received. With the social history available, the social work instructor points out some of the reasons why the young mother may seem unduly apprehensive and suggests various possibilities for student observation in future sessions. Later, when it is timely, the social worker can refer back to the experience and others like it to enhance the students' understanding of behavior and its wide range of differences. If a mother has made good use of the anticipatory guidance and support she has received in the clinic, this important development can also be pointed out to the students.

The social work instructor also tries to empathize with the mother during the clinic visit in order to explain the mother's feelings and behavior, and the possible reasons for them, to the students in the post-clinic discussions. At the same time she tries to be sensitive to the impact of any particular situation on the students in order to help them bring out their questions and feelings in the postclinic discussions or later in an individual conference.

Another function performed by the social work instructor in the well-baby clinic is to help create a situation conducive to learning—a relaxed climate in which the students' curiosity can be stimulated and in which they feel secure in seeking help. While the students find this early-patient contact stimulating, the student-observer role is a strange and anxiety-producing experience for most of them.

In the general orientation at the beginning of the semester, students are provided with written material about course expectations which includes a description of their role in the clinic sessions. However, most of them have had no experience in observational situations and, understandably, they have difficulty in grasping all the implications. Also, the very nature of the clinic sessions poses problems for them. Unless they are helped to feel somewhat at ease early in the course, they have difficulty in using the learning experiences offered to the best advantage.

The parents also tend to feel uncomfortable in this unaccustomed situation of being observed even though the public health nurse told them what to expect when she asked them if they would participate. The whole staff makes an effort to help the mothers feel at ease in talking with the clinician in the presence of the group. The social work and medical instructors and the public health nursing staff work together to promote an informal, friendly atmosphere.

### *Individual Interviews*

Students who are having difficulty or request help with their assigned families have individual interviews with the social work instructor. These conferences are designed to help the student deepen his

understanding of his family and gain some awareness of his own attitudes and how they affect his relationship with the family. The social work instructor is expected to serve as an objective, nonthreatening person to whom the student can reveal his thinking and concerns about his assigned family and any problems he may have in his contacts with them.

For example, one student requested an appointment to discuss a family because, during one of his home visits, the mother had expressed concern about the problem behavior of her 5-year-old boy. Some clues to this problem had been revealed in the clinic sessions but the mother's feelings had been respected when she was unable to discuss the situation there. In the home the student noted the child's aggressive behavior and the mother's inability to cope with it. He said he felt that the parent-child relationship was disturbed but, even though the mother seemed to be asking for help, he doubted that she or the father were yet ready to accept referral to an appropriate agency. Instead, the student had offered to consult with the social work and medical instructors, a suggestion accepted by the mother.

In taking the problem to the social work instructor, the student was testing his observations, seeking more understanding of the family, and asking for guidance on his role. The social work instructor, from her impressions of the mother at the clinic and the additional information furnished by the student, could support much of the student's evaluation. She pointed out to the student the facilitating role he had played by listening to and empathizing with the mother. He was encouraged to maintain his role while the social work and medical instructors took a more active part in helping the mother to work through her resistance to a referral for appropriate help.

Interviews are also scheduled with students who have been selected to present information about their assigned families for discussion at the monthly case conference. It is the rare student who is not apprehensive about his ability to perform before his classmates and instructors. In the interview the social work instructor assesses the degree of the student's anxiety. If this does not seem too great for him to handle, she asks him to describe his assigned family to the class, focusing on a particular aspect of the family situation that emphasizes the concept chosen for discussion in that month's conference. She also helps the student select and organize the material, clarify areas about which he has questions, and resolve any of his own feelings about the family which might impair his ability to make the conference a constructive learning experience for himself and for the class.

Because it is not unusual for students to feel uneasy and guilty about revealing information they have secured about the family to the entire class, the social work instructor tries to help the student chosen to present a case to understand and accept the need for developing skill in the critical evaluation of social as well as medical data. She tries to help him to see that objective evaluation of social history information need not imply punitive or unfavorable criticism of a family. She guides the student in selecting the material to be presented so that he will feel secure in what he is saying about the family, and will be able to recognize the significance and appropriateness of the material to his own and his classmates' learning.

### *Evaluation*

The evaluation of each student's progress is a continuous process interwoven with the functions just described and beginning with the staff's first meeting with the students. Initially, in order to become better acquainted with the students and to establish some baseline of their knowledge in relation to this course, the staff secures information about their educational background and experience. Since most of the students are strangers to each other at the beginning of the semester, this is done in the small group at the clinic, to give the students an opportunity to know more about one another. Even at this early stage some of the more expansive students sometimes reveal attitudes and interests which may have a significant bearing on their probable progress or lack of it in the course or which may alert the faculty to certain learning needs.

Some immediate impressions of the individual students at the first clinic session are gained by the manner in which they conduct themselves: by the way they relate to the instructors, the clinic staff, and the other students in the group; and by their response to their assigned families. The medical and social work instructors and the public health nurses pool these cursory impressions, recognizing that they will be modified and revised later as more knowledge of the students is gained from clinic contact and observation as well as from individual interviews. This information is important in helping students

who have trouble establishing rapport with their families or who are blocked in their learning.

The students' medical school application and subsequent progress reports are available to the social work instructor for review. She keeps a detailed chronological record on each student which includes the data from the application records, her impressions of the students from her observations in clinic sessions, and information gathered through informal discussions, student interviews, and class presentations.

The written reports which the students submit at the end of each semester are reviewed by the medical and social work instructors and the public health nurses assigned to the course. In these reviews they use an evaluation scale developed for this purpose. In addition, the medical and social work instructors prepare written comments on the reports, which are discussed with the students and given them for future use as they follow up their families. Each instructor also gives a general overall evaluation of the report in terms of this particular orientation and makes suggestions as to specific areas needing further exploration. These student reports, along with the chronological records kept by the social work instructors, are used to assess the degree to which the student has been able to assimilate and use the material presented and discussed in the special well-baby clinics, and the extent to which the goals of the family medicine course are being reached.

The two social work instructors who participate in the first year program of the family medicine course function in essentially the same manner, even though they serve in different well-baby clinics with different medical instructors and have been free to create their roles in their own particular ways. The medical faculty has given them support but has not prescribed the methods and content of their work nor in any specific way charted its development. The fact that no marked differences have developed in the way these two social workers operate nor in the content of their work suggests that the medical and social work faculty are in agreement about the essential social work knowledge appropriate for teaching in this kind of medical educational program and about the most effective methods for transmitting it.

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As the individual attributes of the child are observed and interpreted by both parent and physician, a balance between objectivity and subjectivity can be achieved. . . . Parents soon learn that certain types of responses or behavior may be average in this child, whereas in another child in another environment, such a deviation may be an expression of pathology. The infant respected for his individuality may find that this kind of environment requires him to respect others about him for their individuality. . . . The cultivation of an appropriate balance of objectivity to subjectivity in regard to others appears to be a process upon which emotional growth can evolve.

This problem of interpersonal relationship appears to be one of our largest problems for the future. . . . We cannot rigidly impose traditional values, subjectively evolved beliefs and faiths, or political ideology upon others. The real values within each of these must be appropriately defined in the light of the individuality of the person or the social group we wish to aid.

*John A. Anderson, M.D., Professor of Pediatrics, University of Minnesota Medical School, to the 1960 White House Conference on Children and Youth.*

# BOOK NOTES

THE HEALTHY CHILD: his physical, psychological, and social development. Harold C. Stuart and Dane G. Prugh, editors. Foreword by Martha M. Eliot. Harvard University Press, Cambridge, Mass. 1960. 507 pp. $10.

Children's health status in relation to their maturity and growth is considered from many points of view in this textbook for persons in various professions serving children. Its chapters have been contributed by representatives of a number of disciplines—pediatrics, education, nutrition, social work, psychiatry, psychology, preventive medicine, and neurology. They are presented in general subject groupings, such as principles of growth and development; fetal development and childbirth; nutrition; physical, psychosocial, personality, social, and intellectual development; and community health services to promote healthy development. All the discussions emphasize the relation of physical and psychological aspects of child development to family life and other social conditions.

The text consists of an extension and rearrangement of the materials used in large part by the authors in a series of institutes on child growth and development offered by the Harvard School of Public Health to workers in State public health programs.

PARENT GUIDANCE IN THE NURSERY SCHOOL. Margarete Ruben in collaboration with others. Foreword by Anna Freud. International Universities Press, New York. 1960. 72 pp. $2.

This book offers help for nursery school directors and teachers in guiding parents who are disturbed by their children's behavior. A sample or "model" discussion with each of a number of mothers is reported, each on a specified problem, such as thumbsucking, feeding, toilet training, timidity, sleep, and jealousy. Each discussion is based on psychoanalytic educational principles.

While illustrating techniques for parent counseling, the author notes some of their limitations and describes such counseling as an art that is perfected through "experience in human relations and everyday living, supported by an ever-increasing body of knowledge along psychological, educational, and cultural lines."

UNDERSTANDING JUVENILE DELINQUENCY. Lee R. Steiner. Chilton Co., Philadelphia. 1960. 199 pp. $3.95.

In this book the author presents a collection of case stories, based on her experience as a psychiatric social worker, of boys and girls brought before courts for various offenses, including larceny, drug addiction, prostitution, and homicide.

The psychoanalytic approach to treating such children, the author maintains, can succeed only with middle-class boys and girls who are verbally oriented, and not with the action-oriented youngsters of the lower income group—those who chiefly are brought to court. She adds that the fact that most therapists are at least middle class is a handicap in work with delinquents. She opposes laying the blame for a child's actions on the parents, especially as that is likely to make child-parent relations even worse than they were before.

FUNDAMENTALS OF CHILD PSYCHIATRY. Stuart M. Finch. W. W. Norton Co., New York. 1960. 334 pp. $5.95

This textbook's 15 chapters discuss such subjects as psychoneuroses, behavior disturbances, and chronic emotional states in relation to physiologic changes in children; the psychotic child; the handicapped child; history taking and examination; and parental psychopathology.

The author reminds readers that child psychiatry, though a subspecialty of general psychiatry, is not merely adult psychiatry applied to children, and that certification in child psychiatry requires a year more of training than is required for certification in general psychiatry. The book is addressed to students in medicine—especially pediatrics—nursing, psychology, social work, and related fields.

The author is associate professor of psychiatry and director of the Children's Psychiatric Hospital, University of Michigan School of Medicine.

GROWING UP IN NEWCASTLE UPON TYNE: a continuing study of health and illness in young children within their families. F. J. W. Miller, S. D. M. Court, W. S. Walton, E. G. Knox. Published for the Nuffield Foundation by the Oxford University Press, New York. 1960. 369 pp. $5.75

Addressed chiefly to doctors in family practice, in preventive medicine, or in hospitals, who care for children in different ways, this book reports a study of the illnesses in the first 5 years of life of more than 800 children in an English town, in relation to the quality of the care they received from their mothers and to other family circumstances. In the 5 years between 1947, when all the children were born, and 1952, an average of 10 illnesses per child were recorded; minor illnesses were ignored.

The most obvious and most important feature of unsatisfactory family environment noted in relation to the children's illnesses was a low standard of maternal care.

A typical finding was that the incidence of bronchitis and pneumonia was 10 times higher in the families of laborers and other unskilled workers than in professional families. In that connection the authors note that in infancy at least, social factors largely determine whether a given infection will develop as a cold, bronchitis, or pneumonia.

Summarizing their 5-year impressions of the children's human environment in relation to their illnesses, the authors maintain that now, in view of the controllability of serious infection, the reduction of primary poverty, and the improvement of standards of hygiene, nutrition, and education, the major need for child health is improved standards of family behavior.

# HERE AND THERE

## *International Conference on the Family*

The first international conference on the family ever convened in the United States took place in New York, August 23–26, 1960. This was a joint project of the International Union of Family Organizations and the National Council on Family Relations. The meetings were held at Teachers College, Columbia University, with a registered attendance of 1,717, including 127 delegates from 31 foreign countries, many of them officially representing their Governments. Representatives from United Nations agencies, including UNICEF, were also present.

The conference theme was "Personal Maturity and Family Security." In the keynote speech at the opening session Katherine B. Oettinger, Chief of the Children's Bureau, defined "personal maturity" as the ability to "recognize and accept our deep responsibility to work toward the day when a life of freedom and security will be possible for every child in every nation of the world." In the closing address David R. Mace, president-elect of the National Council on Family Relations, dealt with some of the specific problems involved in the quest for international understanding, drawing especially from his experiences in the U.S.S.R. this past summer.

In each plenary session, each section meeting, and each discussion group the conviction was expressed that in the days to come there can be no such thing as security for families anywhere unless the basic needs of families everywhere are met through worldwide cooperation.

As the discussions developed, it became apparent that European and United States delegates approached the question of family security differently. In Europe programs of research and service have concentrated on economic security for the family; in the United States the focus has been on family stability in the psychological sense; and these differences in approach were evident throughout the conference, both in the formal program and in informal discussions among the conferees.

In a paper on economic aspects of family security, Pierre de Bie, president of the Belgian Conseil Superieur de la Famille, said: "Seeing that an international congress is a kind of crossroads, a place where viewpoints come face to face, and ideas are exchanged, I should like to propose an exchange to you now. It is this: that the Americans in the audience leave this meeting more conscious of the measures and institutional mechanisms by which the economic stability and the financial security of families can be reinforced; and that we Europeans return home more sensitive to the need for research into and knowledge of the conditions governing the equilibrium and psychological adaptation of the members of the family."

In summarizing the conference Dr. Evelyn Duvall stressed the following points of general agreement: That family patterns are changing all over the world; that family security includes but is more than economic security; that both "security" and "maturity" are terms which will be more meaningful when they have been more carefully defined. Three major problems of concern to the conference were, according to Dr. Duvall, too early marriages, child rearing dilemmas, and confusions in value systems.

From the discussion groups came such thought-provoking questions as: Isn't *in*security conducive to creativity? Is the egalitarian family really our goal or is flexibility in family roles a more mature concept? Is it not possible that television used internationally could be one of the best means we have for bringing children of the world together? How do we *un*learn judgmental attitudes?

The conferees expressed a strong belief in education for family living, especially parent education, and in professional counseling — premarital, marital, and general family counseling. Many of them also went firmly on record for deeper and more penetrating studies of family life, several members pointing out that the very diversity of research findings could lead to the formulation of more meaningful basic concepts.

It seemed to be generally assumed throughout the conference that education based on the findings of research can help man learn how to live with others, beginning with his family. There was, also, considerable emphasis on the need for clarifying values in the non-Communist world so that these may become a more powerful dynamic in the working out of relations with Communist countries.

Abstracts of all reports of research were available at the conference in mimeograph form as were some of the full papers. Information about the availability of this material may be obtained from the executive secretary of the National Council on Family Relations, Ruth H. Jewson, 1219 University Avenue, SE, Minneapolis 14, Minn. The next international conference on the family will be held in Madrid in 1961.

—Muriel W. Brown

## *International Congress on Nutrition*

Mothers and children were in the forefront of the discussion during many of the sessions of the Fifth International Congress on Nutrition, which took place in Washington, D.C. September 1–7. Childhood undernutrition and malnutrition are major causes of morbidity and mortality in many of the 60-odd countries that were represented by the more than 2,000 delegates to the first of these Congresses to be held in the Western Hemisphere.

Maternal and child nutrition was the focus of a number of summary reports of original research in several scientific sessions as well as of a half-day panel presentation by representatives of seven countries in five continents. Scientific and panel sessions alike gave opportunity for members of the audience or fellow panelists to question the speakers. The nutritional needs of mothers and children were dealt with also in several of the scientific and technical exhibits.

Although differences of opinion on a number of subjects emerged in the panel discussion on maternal and child feeding, there was unanimity on the superiority of human milk for infants. Dr. C. Gopalan of India expressed concern over "an inverse relationship between the position of the mother in the socio-economic scale and her lactation." On the basis of observations in widely

separated tropical countries, Dr. D. B. Jelliffe expressed the opinion that it was probably impossible to reverse the trend to artificial feeding in areas that are already industrialized, but that there might be some hope in averting the abandonment of breast feeding in still underdeveloped areas by application of anthropological knowledge about cultural factors.

Protein requirements of infants and young children received considerable attention. Papers from several countries reported progress in the development of a protein supplement of high nutritive value from mixtures of indigenous plant products. Some optimism was expressed as to the prospects for overcoming the technical difficulties in the way of developing fish flour on a commercial scale for use as a protein supplement in certain countries. Supplementation of a predominantly cereal diet by synthetic amino acids was another possibility suggested.

Throughout the Congress, delegates were reminded that improvements in the quantity and quality of the world's food supply can confer the maximum benefits only on a population that does not exceed the productive capacity of the planet.

The proceedings of the Congress, including the final papers, are scheduled for publication as a supplement to the December 1960 issue of *Federation Proceedings*. The Sixth Congress is to be held in Edinburgh in 1963.

—Marjorie M. Heseltine

## *Conference on Juvenile Delinquency*

Juvenile delinquency, prevention of crime resulting from economic and social changes in less developed countries, short term imprisonment, treatment of prisoners before and after release, and the integration of prison labor in a national economy were subjects discussed at the Second United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in London August 8–20, 1960. The Congress was attended by representatives of governments, specialized agencies, intergovernmental and nongovernmental organizations, and individual participants professionally interested in the subjects to be discussed, such as criminologists, prison officials, law enforcement officers, and social workers. Attendance came to 1,000 persons from 87 countries.

The two items on the agenda of the section on juvenile delinquency, were "New forms of juvenile delinquency: their origin, prevention and treatment" and "Special police services for the prevention of juvenile delinquency."

In regard to the first item the Congress concluded in brief that:

1. The meaning of the term juvenile delinquency should be restricted to violations of the criminal law and should not include offenses for which adults would not be prosecuted.

2. The questions of whether certain forms of delinquency are increasing and if so why, should be the object of study by the United Nations with the cooperation of specialized agencies and nongovernmental organizations.

3. Diversified methods of prevention and treatment are required, including preparation of young people for release from institutions and postinstitutional assistance.

4. Study of "new" forms of juvenile delinquency should continue, and more intensive application should be made of experimental and conventional forms of prevention and treatment, including: (a) efforts by official agencies and committee groups to direct the energies of the young into constructive leisure time activities; (b) intensive studies of the social history of young offenders; (c) invigorated education both of adults and juveniles to increase the understanding and sympathy between them; (d) reasonable steps to reduce the effects of the "abuse of mass media" with sensational material and to stimulate the production of constructive films and literature.

In regard to police services the Congress concluded, in brief, that:

1. The police should not assume specialized functions that are appropriately within the field of social, educational, and other services.

2. The preventive action undertaken by the police should remain subordinate to the observance of human rights.

3. The report of the International Criminal Police Organization, "Special Police Departments for the Prevention of Juvenile Delinquency," represents a sound basis for the organization of such departments.

The Congress expressed "certain reservations" in regard to the finger printing of juveniles or to a police established system of awards or demerits. It stressed the importance of cooperation between the police, specialized agencies, and the general public in efforts toward delinquency prevention.

—Philip G. Green

## *Federal Legislation*

Under the 1960 amendments to the Social Security Act, passed by the 86th Congress before adjournment in September, the Children's Bureau is for the first time empowered to make grants directly to universities or agencies for research or demonstration projects in the field of child welfare. The authorization is included in a special section of title V, which also authorizes a separate appropriation, for which no ceiling is set, to be made for such grants. The grants can be made to public or nonprofit institutions of higher learning or public or other nonprofit agencies or organizations engaged in research or child welfare activities.

The amendments also authorized the Bureau to make grants for special projects in maternal and child health and crippled children's services up to 12½ percent of the amounts appropriated for these programs, not only to the States, as is currently being done, but also directly to institutions of higher learning.

The amendments raised to $25 million each the amounts that can be appropriated for all three of the programs administered by the Children's Bureau under the act. For crippled children's services this is $5 million above the previous authorizations; for maternal and child health services it is $3,500,000 above; for child welfare services, $8 million above.

Appropriations made by the Congress for the year 1960–61 were $20 million for crippled children's services; $18,167,000 for maternal and child health; $13,666,000 for child welfare services. No appropriation was made for grants for research or demonstration projects in the field of child welfare.

## *Child Welfare*

According to a recent decision of the North Dakota Supreme Court, its State court has jurisdiction to terminate parental rights of an Indian couple over their minor children, upon proper cause, when neither parent is living on an Indian reservation even though each is enrolled as an Indian at a reservation. The court noted that the acts

## School Desegregation

Sixteen school districts in seven States have begun school desegregation this fall, according to an announcement made by the Secretary of Health, Education, and Welfare, Arthur S. Flemming, late in September. The Secretary pointed out that figures made available to him by the Southern Education Reporting Service indicate that 325 more Negro students have been admitted to formerly all-white schools in Arkansas, Delaware, North Carolina, Oklahoma, Tennessee, Virginia, and Texas—including the city of Houston, which has had the largest segregated school system in the Nation. In addition about 100 Negro pupils are expected to be admitted to the first grade of New Orleans all-white schools.

Secretary Flemming urged that although this progress is encouraging, "it does not constitute any basis for complacency." He pointed out that 21 public schools in Prince Edward County, Va., padlocked by county officials a year ago to avoid compliance with a Federal-court desegregation order, remain padlocked. About 1,500 white children in this county receive education through private schools provided by a special foundation. Of the 1,700 school-age Negro children about 300 attend schools outside the county; for the rest the only educational facilities available are 16 "training centers" set up by some Negro groups. Calling these training centers a "praiseworthy effort," the Secretary said that "no one would contend that they are an adequate substitute for a normal educational program."

In other parts of Virginia, 11 school districts have begun desegregation, 5 of them this fall.

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cited as grounds for the suit for termination, which was filed in the District Court of Burleigh County, took place not within the boundaries of an Indian reservation but within the territorial jurisdiction of the district court.

The court said: "We find no attempt on the part of Congress to deny recognition of the rule that State courts are open to all persons irrespective of race, color, or citizenship as applied to civil actions by or against Indians not residing on a reservation."

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Development of psychiatric centers for "psychiatrically deviant children"—whether neurotic, psychotic, mentally deficient, or exhibiting character problems—is being recommended by the Group for the Advancement of Psychiatry. The centers would offer diversified programs including inpatient, day hospital, and outpatient services. Such centers, the Group maintains, would make available to the children the therapeutic skills each needs, regardless of the category in which he is classified. The center's first responsibility would be to provide comprehensive differential diagnosis. Then would follow development of a treatment plan based on the concept that the patient is first a child and secondarily a person with an abnormality.

Flexibility in age limits for treatment facilities is also recommended by the Group, which points out that the differences between childhood and adolescence, and adolescence and adulthood, are often indistinct.

The recommendations are embodied in a report, "Basic Considerations in Mental Retardation—a preliminary report, formulated by the committee on mental retardation," available from the Group for the Advancement of Psychiatry, 104 East 25th Street, New York 10; 40 cents a copy.

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One out of every 150 children under 18 in the Washington Metropolitan area in 1958 was living away from home under the supervision of a social agency, according to a report recently published by the Health and Welfare Council of the National Capital Area. The report, "Children Away from Home, Part I, a Staff Report," was prepared by Edward B. Olds. It presents the results of a census of children who were not living with their natural or adoptive parents or other relatives and who were in the care of 42 of the 44 child caring agencies serving the area and estimates of the numbers of children in the care of the two nonreporting agencies.

Of the 4,509 children away from home in the care of the 42 reporting agencies, 2,791 were dependent and neglected, 962 were delinquent, 546 were mentally retarded, and 210 were emotionally disturbed. Fifty-eight percent of the children living away from home were nonwhite as compared with 27 percent of nonwhite children in the total child population. The data on terminations of care showed a considerably higher termination rate for white (78 percent) than nonwhite (21 percent).

## *Children on ADC*

Less than 4 percent of the children under 18 in the United States were receiving public assistance through the Federal-State aid to dependent children program in December 1958, according to a report of a biennial survey of facts about families in the program recently issued by the Bureau of Public Assistance, Department of Health, Education, and Welfare. Among the facts about the 745,000 families, including 2,142,000 children, who were receiving such aid at that time the Bureau reports that:

- Six of every 10 families were white; 4, nonwhite.
- The children's median age was 8.4 years; 77 percent were under 13.
- Most of the children had been on the ADC rolls for a short time; the median was 2.1 years.
- Ten percent of the fathers were dead; 26 percent incapacitated. Among the other fathers, 5 percent were imprisoned; 13 percent were divorced or legally separated from the mothers; 8 percent were separated without a court decree; 19 percent had deserted; 16 percent were not married to the mothers.
- The families' average monthly income from all sources amounted to only 21 percent of the national per capita monthly income. In many States ADC payments were inadequate to meet the State's own standard for the families' financial requirements. Forty-eight percent of all the families in the program did not receive enough income to meet their needs; the average monthly shortage was nearly $39.
- Fifty-five percent of the families had no income other than payments under public assistance programs. The others received income from various sources, averaging $24 a month; in 13 percent, cash earnings of the mother; in 12 percent, money contributions from

absent fathers; in 6 percent, social insurance benefits.

• Families with the mother employed included 87,000 children under 6 years of age and 165,000 with children 6–12 years. Arrangements for care in the home or elsewhere while the mothers were working outside the home had been made for 89 percent of the children under 6 years and for 78 percent of those 6–12.

## *Radiological Health*

Since last March the Public Health Service has increased from 10 to 59 the number of sampling stations for measuring radioactivity in milk. Coverage is now almost nationwide, with at least one sampling station in each of 47 States, the District of Columbia, and Puerto Rico.

Data from the sampling stations published by the Service in July showed that the average measurements of strontium-90 in milk, in micromicrocuries per liter, during the period Febrary 1959 through January 1960, ranged from 3.4 for Overton, Nev., to 22.4 for Saint Louis, Mo. These averages, the Service points out, are well below the level of 33 micromicrocuries per liter or kilogram for water and for milk and other foods, recommended as a guideline by the National Committee on Radiation Protection and the International Commission on Radiation Protection. That level has been adopted as a radioactivity concentration guide by the Department of Health, Education, and Welfare pending completion of studies by the Federal Radiation Council, an advisory body established last year by President Eisenhower.

. . .

A serious deficit exists in the number of experts trained to cope with the public health and safety problems accompanying the rapidly expanding use of radiation of various kinds throughout the Nation, according to estimates made by the Public Health Service. For example, only 10 medical radiation physicists are being trained each year, though the estimated need in major hospitals and health agencies is for an increase of 100.

By 1970, according to the estimates, at least 1,000 additional physicians, engineers, and physicists, with extensive training in radiological health and protection measures, will be needed; and to reach that number, the Nation's colleges and universities should be admitting annually at least 600 candidates for such training. Currently only about 200 are receiving it.

These estimates were presented at a 3-day symposium on the subject of personnel needs in this field called together by the Public Health Service in Princeton, N.J., last August. Participants representing the faculties of a number of colleges and universities expressed recognition of the urgency of the need and a willingness to work to meet it.

The Public Health Service itself has been conducting a series of short courses in radiological health during the past 10 years. Last year (1959–60) 386 persons from public agencies and private industry took these courses. About 600 are expected to take the courses this year and about 1,000 next year.

## *Financing Services*

The Rockefeller Foundation has appointed an ad hoc committee of civic leaders, with a study director and a professional advisory staff, to make a year's exploratory study of the voluntary support of local, regional, and national health and welfare agencies.

The committee will look into such questions as:

• Are there criteria by which the public can evaluate the programs and operating methods of such agencies?

• What is the impact on private agencies of expanding governmental activities in health and welfare?

• Are research and professional education being adequately supported by voluntary agencies?

• Are there principles and methods of community planning that encourage cooperative efforts among private and governmental agencies?

• Is there a solution to the disagreement between agencies committed to federated fund-raising and those which raise funds independently?

Hospitals will be excluded from the scope of the study as having unique problems which have already been the subject of many special studies.

If at the end of the year's work the committee recommends further comprehensive study, it will make detailed proposals for examination of special problems and will suggest whether the larger study should be conducted by the committee itself or by a new group.

According to the Foundation, philanthropic giving for health and welfare services, research, and education has nearly doubled within the past decade, reaching $7.8 billion in 1959, while the governmental share of health and welfare financing has grown even more rapidly.

## *Against Polio*

On the basis of recommendations by the Public Health Service's advisory committee on live-poliovirus vaccine, the Surgeon General on August 24, 1960, announced that the Sabin live virus vaccine is now considered suitable for use in the United States. The safety and effectiveness of the vaccine, which has had extensive field trials abroad and on a smaller scale in this country, have been under study by the committee for the past year. (See CHILDREN, September–October 1959, p. 194, and November–December 1959, p. 236.)

The vaccine, which can be taken orally, was developed by Dr. Albert B. Sabin at the University of Cincinnati. Recommendations which will form the basis for the manufacturing regulations have been drawn up by the advisory committee and will have legal status after they are published in the *Federal Register*.

. . .

The Public Health Service recently announced formation of a Surgeon General's Committee on Poliomyelitis Control, to be made up of representatives of the medical and health professions and the general public. The Children's Bureau is among the 23 agencies and organizations which have been asked to designate members to serve on the committee.

The group will meet in midwinter to consider the questions in relation to the administration of the live virus vaccine, such as how the use of the new vaccine can be integrated with the use of the presently available Salk killed virus vaccine, and whether or not the administration of the live virus vaccine would be more appropriate on a community than an individual basis.

## *White House Conference*

At a meeting in Washington on September 19, the President's National Committee for the 1960 White House Conference on Children and Youth voted

to transfer the residual funds of the Conference to the new National Committee for Children and Youth, which has been set up to stimulate implementation of the Conference recommendations and widespread use of its materials. (See CHILDREN, September–October 1960, p. 196.) Officers of the new committee, elected in September, are: *Chairman;* Mrs. Thomas Herlihy, Jr., Delaware State Labor Commission; *vice chairmen,* Luther H. Foster, Tuskegee Institute, and Katherine B. Oettinger, Children's Bureau; *secretary,* Sylvia Carothers, Florida Children's Commission; *treasurer,* Lyle W. Ashby, National Education Association. Mrs. Isabella J. Jones, who was associate director of the White House Conference, has been appointed director of the new committee.

On October 10 the executive committee of the President's National Committee as its final action presented a specially bound copy of the Conference proceedings, just off the press, to the President of the United States.

The 429-page book has four parts and an appendix. Included are sections on the history and organization of the Conference, the program and exhibits, highlights from the Conference sessions, and the composite report of the forum recommendations which has already been published separately. In the section on the Conference sessions are the full texts of some major addresses, including those of President Eisenhower and of Arthur S. Flemming, Secretary of Health, Education, and Welfare, and abstracts of all speeches from the forums and theme assemblies.

The proceedings are available from the National Committee for Children and Youth, Room 411 Association Building, 1145 19th Street, Washington 6, D.C. (Price $2.60 including cost of mailing.)

A volume of selected papers from the Conference is soon to be published by Columbia University Press.

### *Miscellaneous*

"International Society for the Rehabilitation of the Disabled" is the new name of the former International Society for the Welfare of Cripples. The name was changed at the Eighth World Congress of the society, which was held in New York, August 29–September 2, 1960, with some 3,000 delegates from 79 nations attending.

. . .

Representatives of parent cooperatives in 10 States, two Canadian Provinces, and the District of Columbia formed a national association, the American Council of Parent Cooperatives, at a meeting in New York City, August 22–23, 1960. Parent cooperatives include nursery schools, kindergartens, and other educational arrangements for pre-school children and their parents, operated by parents. The parents work with trained teachers who are in charge of the children. Many programs of this type are being carried on across the country. Among the oldest are those in Seattle, Wash.; Baltimore, Md.; Long Beach, Calif.; and Montgomery County, Md.

Mrs. Roy Harkins, of Birmingham, Mich., is president of the new organization.

. . .

A new national citizens' organization, the National Family Life Foundation, was recently organized in New York to work toward unifying the many efforts now being made to preserve and strengthen family life in the United States. The group is planned as a central resource agency, carrying out and promoting research on family life, identifying needs not being fulfilled by existing programs in the field, recommending and sponsoring programs aimed at fulfilling those needs, acting as a clearing house for research results and other information, stimulating educational programs, and bringing together existing organizations in conferences. The foundation's president is Philip Mather of Boston; its headquarters, 225 West 57th Street, New York 19; its executive secretary, Conrad Van Hyning, who is also director of the American Social Health Association. The foundation is seeking support from philanthropic foundations, industry, and individuals.

# Guides and Reports

AN INTERDISCIPLINARY APPROACH TO ACCIDENT PATTERNS IN CHILDREN. Irwin M. Marens and others. Monographs of the Society for Research in Child Development, Vol. 25, Serial No. 76, No. 2. Child Development Publications, Purdue University, Lafayette, Ind. 1960. 79 pp. $2.50.

Compares children who have had several accidents with enuretic children and with a control group in regard to psychological, physical, and intrafamily factors and to behavioral responses; finding many similarities between the accident-prone and the enuretic children.

EMOTIONAL ASPECTS OF SCHOOL DESEGREGATION; a report by psychiatrists. Group for the Advancement of Psychiatry, 104 East 25th Street, New York 10. 1960. 48 pp. 50 cents. Discounts on quantity orders.

A condensed and less technical version—including new material—of a 1957 report, "Psychiatric Aspects of School Desegregation" (see CHILDREN, January–February 1958, p. 37), this report examines the psychological effects of school segregation on children, parents, and teachers, as well as on the country and community; and discusses the origins of prejudice and possible ways of changing negative attitudes toward desegregation.

CHILD WELFARE LEAGUE OF AMERICA STANDARDS FOR SERVICES TO UNMARRIED PARENTS. The League, 345 East 46th Street, New York 17. 1960. 74 pp. $1.50.

Presents standards for a number of types of professional services for unmarried parents—social casework and groupwork, medical and hospital, adoption, and other welfare and health services.

# AID TO DEPENDENT CHILDREN IN LOUISIANA

IN early October the Commissioner of Social Security notified the Department of Public Welfare in Louisiana of a hearing to be held later in the fall to determine whether the State's program of aid to dependent children is in conformity with the requirements of the Social Security Act and so acceptable for continued Federal support. Under the variable formulas for State reimbursement, Louisiana has been receiving 75 percent Federal reimbursement for money expended on the program.

The notification followed the revision of the "suitable home" provision in the State's plan to conform with new State legislation—which resulted in about 22,500 children and 6,000 mothers being dropped from the rolls in mid-July.

The new State law, passed in June, prohibits payments under the aid-to-dependent-children program to families in which the home is unsuitable for a child and defines this as a home in which a man and woman are living as husband and wife without being legally married. It also requires assistance to be discontinued if the mother has had an illegitimate child after she has received an assistance check—no matter how long ago that was—until the parish (county) welfare board finds that she has ceased illicit relations and is now maintaining a suitable home.

The same legislature in another act made it a criminal offense to enter into a common-law marriage or to produce two or more children out of wedlock.

ABOUT 90 percent of the 22,500 children were dropped from the rolls because the mothers had given birth to an illegitimate child after receipt of assistance. In all dropped cases assistance was denied to all children in the case. School children in many of these families are not receiving free school lunches.

Under the State law, to have assistance reinstated the mother must reapply and have a determination of suitability made by the parish welfare board. The agency has ruled that placement of the children in suitable homes of other relatives will not make a child eligible for aid to dependent children.

About 540 cases had been reinstated by September 14, and about one-half of the cases would be reinstated by November, according to the State welfare agency.

Early in September the director of the Bureau of Public Assistance asked the Louisiana Department of Welfare for a report on its actions in regard to these children, pointing out that "to deny assistance . . . to children who have already been determined to be needy without making provision for their maintenance and care seems to run counter to the type of responsibility placed in State welfare departments for the protection of children." The State agency was asked to describe the steps being taken to protect "the large numbers of children purportedly living under conditions so unsuitable that the State feels impelled to withdraw from them sufficient aid to provide the necessities of everyday living." The letter also asked for assurances on a number of specific issues having a bearing on conformity with Social Security Act requirements.

THE Commissioner's notification of the impending hearing pointed out that the State's reply to the communication from the Bureau of Public Assistance had left many serious questions unresolved. Four which it specified were, in brief: (1) whether the State is in conformity with Federal requirements in automatically dropping one-fourth of the ADC cases from the rolls, even though more than one-half are expected to be eligible upon reapplication; (2) whether the State plan provides an opportunity for a fair hearing to families dropped from the rolls; (3) whether recipients have been dropped from the rolls without proper determination of their ineligibility, based on current facts; (4) whether the State requirements which resulted in these terminations were designed to deprive needy children of aid "solely because of the conduct of a caretaker relative which the State has found to be offensive, but not necessarily of adverse effect to the children."

In the meantime some local and national groups were making efforts to meet the emergent needs in families left destitute by the withdrawal of aid. In New Orleans, where 5,300 of the children lived, the city made $4,000 available for emergency assistance. The local Urban League led a drive to secure voluntary funds, largely through churches, for emergency aid. A statement issued by the League in late September reported that its offices were beleaguered by hungry women and children seeking money for food, medical supplies, and rent, and that many of them had been evicted from their homes.

THE National Urban League, in initiating a nationwide drive for funds, pointed out that in Louisiana areas outside New Orleans "there were practically no rescue facilities because of total lack of organizational structure that might aid Negroes." About 95 percent of the children dropped from the rolls are reported to be Negroes.

Indications that the situation was also receiving international attention came when $400 worth of free baby food labeled "Bundles from Britain" was sent to Louisiana by a group of city councilwomen in Newcastle, England.

In communications sent to the Secretary of Health, Education, and Welfare late in September, the Committee on Social Policy of the National Social Welfare Assembly and many of the Assembly's member agencies urged the Federal Department to adhere to the general policy that a home is suitable for receipt of assistance until a court decision has removed the children.

In 24 States the ADC programs carry some reference to the responsibility of the agency to see that children are in suitable homes, according to a report recently issued by the Bureau of Public Assistance, "Illegitimacy and its Impact on the Aid to Dependent Children Program." In 18 of these the State continues assistance until the home meets the test of suitability or until other arrangements have been made for the children. In six, the State plans deny assistance without assurance that an arrangement for the child's upbringing is worked out.

# IN THE JOURNALS

## *Support of Orphans*

An estimated 86 percent of United States children whose fathers die are awarded benefits each year under the old-age, survivors, and disability insurance provisions of the Social Security Act, according to a report in the *Social Security Bulletin* for September 1960. ("Money Income Sources of Young Survivors, December 1959," by Mollie Orshansky.) At the end of 1959 about 12 percent of such paternal orphans were receiving benefits under more than one public income maintenance program, usually both OASDI and veterans' compensation or pension payments.

Public assistance, in the form of aid to dependent children, provided income in 1959 for 225,000 children whose fathers were dead, the article states—about 11 percent of the total. An estimated 95,000 of these—about 40 percent—were also beneficiaries of social insurance or related programs.

Of the 740,000 widowed mothers who in 1959 had children under 18 in their care, 395,000 were receiving support from social insurance and related programs and 75,000 from federally aided public assistance; 30,000 received payments from both sources.

More than half of all the widowed mothers had employment during 1959, but 40 percent of those who worked also received payments from some type of public program. Among divorced or separated mothers with children under 6, the proportion working was one-third again as high as among widows with children in the same age group.

## *Management of Epilepsy*

A child who has had one epileptic seizure, especially a teenager, is likely to suffer greatly from fear of having a second one and should be treated immediately in an effort to prevent recurrence and to relieve emotional disturbance in him and in his parents, says Samuel Livingston, M.D., in the *Journal of the American Medical Association* for September 10, 1960. ("Management of the Child With One Epileptic Seizure.")

Emotional disturbances in epileptic children and their parents are sometimes a greater problem than the seizures, says the author, who is director of the epilepsy clinic at Johns Hopkins Hospital. He adds that much harm may be incurred by both child and parents if no attempt is made to prevent the recurrence of an unquestionable epileptic seizure. Noting that some seizures are not classified as epileptic, he points out that his recommendation for immediate and prolonged treatment depends on the diagnosis of the individual child.

The author reports a considerable reduction of recurrences of seizures in patients at his clinic since the program of administering prolonged anticonvulsant therapy to children who have had one seizure was introduced 9 years ago.

## *Circular Residences*

In *Hospitals*, journal of the American Hospital Association, for September 1, 1960, a nurse and an architect join in proposing an experimental plan for a residence unit for emotionally disturbed children, constructed in the form of a circle, "traditionally a symbol of warmth, closeness, and protection." ("Living in a Circle: a proposal for a residence for disturbed children," by Gladys M. Hillsman and Paul D. Spreiregen.) The unit described is planned as an annex to an already established children's hospital. A separate school unit, also circular, is included in the plan. The authors explain that going to school outside the residence unit would lessen children's feeling of being hemmed in.

When the child first approaches the residence with his parents, the authors maintain, a circular unit, instead of reminding him of a school, a hospital, or a courthouse, where he may have been unhappy, is likely to remind him of a tent, perhaps a circus tent. Later, when his bedroom is one of a number arranged around a central office, he can be observed by the staff without loss of privacy; also, he will feel less deserted by adults if he can lean over in bed and see that a staff member is near, but, the authors add, "not too near."

## *The Emotionally Disturbed*

Pointing to the fact that improvement of emotionally disturbed children depends largely on improvement in family relationships, Joseph J. Reidy, M.D., in the *Southern Medical Journal* for September 1960, notes types of interaction between child and parents at various stages of childhood which may cause disturbance in the child. ("The Emotionally Disturbed Child: problems within the family.")

In the diagnosis and treatment of such children, the author, a child psychiatrist, urges that more emphasis be placed on knowing about the family unit and on recognizing that concepts of normal and abnormal behavior in adults do not apply to the child, whose personality is developing.

Furthermore, he urges that no child be removed from his own home until all resources and skills have been used to mend the family, or unless the child shows a specific need requiring placement out of the home, such as a need for experience in corrective group living, for gaining better relations with authority figures, or for gaining mastery over his impulses.

## *Adoption Practices*

Misunderstandings concerning agency adoption procedures, and principles and guidelines for adoption practice, are discussed by Ross T. Wilbur in *Iowa Public Welfare in Action*, Summer 1960.

Among widely believed "myths" discussed by the author are: that many children in institutions are available for adoption; that agencies' screening of applicants for a child is arbitrary; and that the interests of the medical, law, and social work professions conflict in the adoption field. Some of the myths, he suggests, are encouraged by inadequate explanations by the agencies concerning their practices.

The author sets forth guidelines for adoption practices based on protecting the rights of the child, of the natural parents, and of the adoptive parents, and he adds that there is little doubt that the public at large subscribes wholeheartedly to practices based on those principles.

# READERS' EXCHANGE

GOLDBERG: *Lawyers and Social Workers*

Harriet L. Goldberg's presentation of the community of interests and needs of social workers and lawyers is a helpful consideration of a longstanding problem in relationships, and her treatment of some particularly vexing problems in the adjudication process should be of value to lawyers and social workers alike. ["Social Work and Law," by Harriet L. Goldberg, CHILDREN, September–October 1960.] It is indeed encouraging to read her documentation of a dozen or more movements toward increased collaboration and mutual respect between these two professions.

It could have been emphasized, however, that the largest area of misunderstanding, if not actually antagonism, concerns the respective roles of lawyer and social worker in the adjudication process. While the social worker is not alone responsible for this misunderstanding he can at least contribute responsibly to a resolution of it by gaining an understanding and appreciation of the nature and function of the legal process. If he is to play a part in this process, he would do well to gain a degree of understanding sufficient to clarify and identify his own special role. The deeper his understanding and appreciation, the sharper and clearer his role, the more rapidly will there be achieved a resolution of the misunderstandings and conflict.

The social worker can take some comfort, however, in the fact that he is not alone with this problem. He has notable companions in the physician and the psychiatrist. An attorney might welcome all three on many occasions, but he generally is apt to consider them a problem in the courtroom. He would, on the other hand, certainly welcome a social worker who appreciated the hard-won elements of due process and who contributed to the adjudication process within the framework of the law's methods and objectives.

Miss Goldberg has done such a nice job in setting forth the meaning of a "fair hearing" and in considering the complexities of the "social study," I trust she will find it possible to prepare a series of articles which detail other parts of the legal process as a further contribution toward enhancing the social worker's understanding.

*C. Wilson Anderson*
*Commissioner, Office for Children and Youth, Pennsylvania Department of Public Welfare, Harrisburg.*

BRADWAY: *Perceptible Improvements*

In his article in the September–October issue of CHILDREN John S. Bradway brings us face to face with the many facets of the problems involved in family law. ["A Suggestion for Improving Family Law," by John S. Bradway, CHILDREN, September–October 1960.] His concept of a group of "nonspecialized but trained individuals," who might be in a position "to fit the innumerable pieces of the gigantic jigsaw puzzle of family law together" is an intriguing one.

It occurs to me, however, that it is because lawyers and social workers are beginning "to see across" their respective professions that progress is being made in the field of family law—glacial progress perhaps, but nonetheless perceptible. Mr. Bradway himself for many years has bridged the gap between these two professions.

The recent Standard Family Court Act was prepared by a committee of the National Probation and Parole Association (now the National Council on Crime and Delinquency) in cooperation with the National Council of Juvenile Court Judges and the Children's Bureau. Included were judges, lawyers, social workers, correctional workers, and public welfare administrators.

The Committee on Lawyer-Family Agency Cooperation of the Family Service Association of America and the new Family Law Section of the American Bar Association, which Mr. Bradway mentions, are other evidences of interest at the national level in the improvement of family law.

Some State and local bar associations also have established committees in family law. Important changes in procedures in desertion and nonsupport cases in Allegheny County, Pa., are being made as a result of joint activity by committees of the county bar association and the local health and welfare association.

The behavioral science center at Stanford University, the law and behavioral science fellowships at the University of Chicago, the institute on family law held in 1959 at Duke University, are all examples of the recognition today of the need to pool the knowledge of the various disciplines.

Almost 40 years ago Roscoe Pound, then dean of the Harvard Law School, said that when we look at the core of the different organized bodies of knowledge that treat of different aspects of social life, the analytical distinctions are sound enough, "but we shall not understand even that core, and much less the debatable ground beyond, unless we are prepared to make continual deep incursions from each into each of the others. All the social sciences must be coworkers, and emphatically must be coworkers with jurisprudence."

*Mary T. Denman*
*Attorney at Law, and Consultant on Public Welfare, Pennsylvania Citizens Association for Health and Welfare, Pittsburgh.*

BOGGS AND NORDFORS: *Author's comment*

There was one omission relating to the article by Mr. Nordfors and myself which I hope may be somehow rectified. ["Care of the Mentally Retarded in Sweden," by Elizabeth Boggs and Gösta Nordfors, CHILDREN, July–August 1960.] It was a United Nations fellowship which enabled Mr. Nordfors to make an extensive tour of the United States in 1956; it was during this tour that he and I met and talked at length about the new Swedish law; out of these conversations grew our article. It might also be worth noting that Mr. Nordfors was a member of the special legislative commission, chaired by a member of the Swedish Parliament, which worked for several years to develop the comprehensive law, enacted in 1954.

We agree with Lewis A. Dexter that there may be wide gaps between legislative prescription and practice. [See Readers' Exchange, CHILDREN, September–October 1960.] I had a chance this past summer to observe some of the advances Sweden has made in prac-

tice since 1954. It is too early to evaluate all aspects.

I am sorry that we did not make clear to Mr. Dexter that the *annual* registration (census) lists all citizens, not all defectives as such. An accounting of school status of school age children is a byproduct. "Registration" as a retardate is a separate process with emphasis on clinical evaluation and need for service rather than on statistical completeness or IQ cutoff point. Since the slow learners and high "educable" retardates are not included, Swedish authorities estimate that less than 1 percent of the population will qualify for the program described in our article.

*Elizabeth Boggs*
*President, National Association for Retarded Children, New York*

### *Other programs for the retarded*

The comparison of programing for the mentally retarded in different countries is always difficult, since the culture, habits, and social customs vary enormously. As Mrs. Boggs and Mr. Nordfors have pointed out in their article about Sweden's program, each area develops a program which is fundamentally suited to its population and environmental needs.

In Great Britain, the national Government has now assumed responsibility for the care of all retarded, and has subdivided this responsibility to regional boards. Care is free. Day centers for training and education, and sheltered workshops are provided. There are halfway houses and "homes" for groups of workers.

In Canada, as in Sweden, there are provinces. These provinces vary in their overall size and population numbers, but are responsible for the care of their own mentally retarded.

In Saskatchewan a system of workhome placements has been established. These are controlled from the central residential school by its psychiatric social workers. Foster home placements are arranged by the school and are the responsibility of the school. Placements in such homes are from the school only, and no placement can be made directly from the child's own home. Cluster placements are found to be of most value since they make the break from the central school less difficult.

An IQ level of 75 or below is considered in Saskatchewan to mean retardation. For those above this level, but still below average, special classes are available in the public school system. In Britain the IQ level is not the overriding factor. Persistent social problems are considered an indication of deficiency requiring special training and education.

*A. J. Beddie*
*Superintendent, Saskatchewan Training School, Moose Jaw, Saskatchewan, Canada*

### WAITE: *Social action process*

Miss Waite's article on the process followed in Wisconsin to secure a law authorizing the State welfare department to establish a residential treatment center for emotionally disturbed children illustrates the effective bringing together of many professional and voluntary interests concerned with the welfare of children. [See "Winning a Victory for Emotionally Disturbed Children," by Dorothy Waite, CHILDREN, September–October 1960.] The process of securing such interdisciplinary and public-private agency cooperation takes time. The proper treatment of emotionally disturbed children concerns too many agencies for short cuts to be possible.

It is surprising to read that at the last minute the State university's medical school raised questions about vesting the administration of the new center in the State welfare department. Apparently, the medical school was not a party to the original planning although it was interested in having such a center for training personnel and for research. This situation exists in many places and deserves more study. Administrative agencies are needed to handle State service programs. A medical school cannot give complete coverage of service where needed, but has to select the cases to be served on the basis of clinical material for teaching and research purposes. Since we need both more trained specialists and more skillful services from the State government, more attention must be given to ways of achieving both.

The lesson learned in Wisconsin from not using the legislative council at the very beginning of the attempt to secure the treatment center is also important for social workers. The eventual resort to a 2-year study involving the active participation of several key legislators and influential citizens was excellent. The welfare department's frank presentation of the unpleasant matter of high costs must have inspired faith in its integrity. Surely the sponsors will not be expecting magic, but only moderate results after much hard work.

The last-minute difficulty in securing the bill's passage, which occurred when the difficulty with the medical school arose, indicates that legislatures will not be used to settle disputes or differences in philosophy of administration between several State departments.

While the article mentions the fact that the State education department participated in the social action efforts, the role it played does not become clear.

Similarly, what was the participation of county officials in the developments? This is not mentioned. The district clinics will require county payments, and counties would probably be sharing expenses more willingly after taking part in the study and in efforts to pass the bill.

I would also like to know more about the structure that operated the publicity and lobbied for the bill. Apparently the Wisconsin welfare department has a standing advisory committee free from political and administrative responsibility. Did this committee become the central channel for promoting the bill? Was mail to and from citizen organizations routed through it? Did it supply the staff time and money needed for coordinating the efforts of so many organizations?

A State department seeking a major expansion of its services opens itself to the charge that it wants to aggrandize its position and secure more authority over local governments, if it does more than supply and interpret the facts behind its recommendations. Citizens who will not be directly involved in operating a new program are essential in the efforts to secure the necessary legislation.

*Esther L. Immer*
*Executive Secretary, Iowa Commission on Children and Youth, Des Moines, Iowa*

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These are the last 10 of the projected series of documents on juvenile delinquency addressed to a technical audience. The first six were noted in the May June 1960 issue of CHILDREN.

Number 7 presents some of the problems involved in accomplishing effective coordination—administrative, interagency, and citizen participation—at local, State, and Federal levels.

Number 8 reviews training needs for personnel for delinquency treatment and prevention and recommendations for the establishment of effective interdisciplinary relationships.

Number 9 reviews selected studies, reports, and projects concerned with the effectiveness of services and suggests need for more frequent and comparable evaluative studies.

Number 10 presents results of study of existing expenditures and estimated standard costs in different sections of the country for the four types of services police, detention, probation, and training schools indicating program and dollar deficiencies in each.

Number 11 reviews some of Erik H. Erikson's theories about adolescents as possible bases for action research in relation to delinquency.

Number 12 summarizes reports from 52 State public welfare departments regarding the nature and extent of each State's legal responsibilities, functions, and operation in the control of juvenile delinquency.

Number 13 reports on information obtained in a nationwide survey from 573 urban police departments regarding the adequacy of staff for specialized juvenile units, the educational requirements for appointment to them, and the provision of training programs for recruits and juvenile officers.

Number 14 reports on the results of a survey of activities, sponsored by community councils and other community groups, designed specifically to prevent juvenile delinquency.

Number 15 presents, among other facts, information on probation officers' education, salaries, and length of employment, obtained from questionnaires sent to a selected group of 502 courts.

Number 16 reports on the past experience in the correctional field of 218 sociologists teaching undergraduate specialized courses in corrections.

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